Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

March 11, 2013

RHP 1 / The Northeast Texas Regional Healthcare Partnership

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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 HHSC Waiver Mailbox
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 responsibiility 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 finanical 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)
Anchoring Entity						
Academic Medical Center	127278304	17560013546000	State Owned	The University of Texas Health Science Center at Tyler - Hospital	Daniel Deslatte	11937 US Hwy 271 Tyler, Texas 75708 daniel.deslatte@uthct.edu 903-877-5077
IGT Entities						
Academic Medical Center	127278304	17560013546000	State Owned	The University of Texas Health Science Center at Tyler - Hospital	Vernon Moore	11937 US Hwy 271 Tyler, Texas 75708 vernon.moore@uthct.edu 903-877-2831
Academic Medical Center	127278302	17529317209000	State Owned	The University of Texas Health Science Center at Tyler – MSRDP (University Physician Associates)	Vernon Moore	11937 US Hwy 271 Tyler, Texas 75708 vernon.moore@uthct.edu 903-877-2831

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Local Mental Health Authority	137921608	17517240176003	Non-State Public	Community Healthcore	Rick Roberts	107 Woodbine Pl Longview, TX 75601 Rick.roberts@communityhealthcore.com 903-237-2338
Local Mental Health Authority	138365512	17512814108000	Non-State Public	Andrews Center	Waymon Stewart	2323 West Front Street Tyler, TX 75702 wstewart@andrewscenter.com 903-597-1351
Hospital Authority	139173209	17518545673001	Non-State Public	Henderson County Hospital Authority	Martin Bennett	P.O. Box 1102 Athens, TX 75751 mbennett@ksbpc.com 903-675-5151
County	N/A	17560011060000	Non-State Public	Panola County	Sidney Burns, County Auditor	110 S. Sycamore, Room 213-A Carthage, TX 75633 Sidney.burns@co.panola.tx.us 903-693-0320
Hospital Authority	N/A	17560023016000	Non-State Public	Red River Hospital Authority	William Bryson President	206 N. Donoho Clarksville,TX75426 903-427-3638
Hospital District	N/A	17512853213000	Non-State Public	Houston County Hospital District	Dick Murchison	500 E. Houston Street Crockett, Texas 75835 dickmurchison@windstream.net 936-544-8082
Hospital District	751803325	17417746694000	Non-State Public	Fairfield Hospital District	Tony Price Executive Assistant	734 West Commerce St. Fairfield, TX 75840 Tony.Price74@hotmail.com 903-389-8379
County	N/A	17560009551003	Non-State Public	Franklin County	Paul Lovier	200 N. Kaufman Street Mt Vernon, TX 75457

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)
						fcjudge@mt-vernon.com (903)537-4252, Ext 6
County	N/A	17560008454012	Non-State Public	Camp County	Thomas Cravey	126 Church Street Pittsburg, TX 75686 (903)856-3845
Hospital District	N/A	IGT Entity is applying for a new TIN based on feedback from HHSC.	Non-State Public	Wood County Central Hospital District	Jack Dickerson	417 Nathan Quitman, TX 75783 jdickerson@suddenlink.net 903-763-5030
Hospital District	N/A	17600776236000	Non-State Public	Trinity Memorial Hospital District	Larry King	P. O. Box 3169 Trinity, Texas 75862 pking@etmc.org 936-744-1125
Hospital District	1310385-04	17512772934501	Non-State Public	Hunt Regional Medical Center Greenville	Richard Carter	4215 Joe Ramsey Blvd Greenville, TX 75403-1059 rcarter@huntregional.org 903-408-1605
Local Mental Health Authority	136367307	17514423932000	Non-State Public	Burke Center	Susan Rushing	2001 S Medford Drive Lufkin, Texas 75901 SusanR@burke-center.org 936-633-5602
Hospital District	131037704	17560018123000	Non-State Public	Hopkins County Memorial Hospital	Michael McAndrew	115 Airport Road Sulphur Springs, TX 75482 michaelm@hcmh.com 903-439-4051
Local Mental Health Authority	121988304	17528338233000	Non-State Public	Lakes Regional MHMR Center	John Delaney	400 Airport Rd. Terrell, TX. 75160 johnd@lrmhmrc.org 972-388-2000 ext.1150

RHP Participant Type	**Texas Provider Identifier** (TPI)	**Texas Identification Number** (TIN)	**Ownership Type** (state owned, non-state public, private)	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information** (address, email, phone number)
Local Public Health Department	140425362	17560022067001	Non-State Public	Paris-Lamar County Health Department	Gina Prestidge	740 SW 6th Street Paris, TX 75460 ginap@suddenlinkmail.com 903-785-4561
Local Mental Health Authority	084434201	17514523608014	Non-State Public	Texoma Community Center	Sylvia Cave	P. O. Box 1087 Sherman, TX 75091 scave@mhmrst.org 903-267-9616
Hospital District	138913209	17560039350000	Non-State Public	Titus Regional Medical Center	Terry Scoggin	2001 N. Jefferson Mount Pleasant, Texas 75455 Terry.Scoggin@titusregional.com 903-577-6066
Local Public Health Department	1383606-06	17522545445000	Non-State Public	Northeast Texas Public Health District	George T. Roberts, Jr., FACHE	315 N Broadway, Ste 404 Tyler, TX 75702 groberts@netphd.org 903-535-0036
County	N/A	17560008298320	Non-State Public	Bowie County	Sterling Lacy	710 James Bowie Drive New Boston, Texas 75570 Sterling.lacy@txkusa.org 903-628-6718
Hospital Authority	133255305	12370332400005	Non-State Public	Atlanta Hospital Authority	Sheila Robinson	1007 S William Atlanta, Texas 75551 sjrobinson@atlantamemorial.com 903-799-3000
County	N/A	17560009718004	Non-State Public	Gregg County	Laurie Woloszyn	101 E Methvin Longview, TX 75601 Laurie.Woloszyn@co.gregg.tx.us 903-237-2680
County	N/A	17560010476000	Non-State	Lamar County	Chuck Superville	119 N Main

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)
			Public			Paris, TX 75460 Judge_Superville@co.lamar.tx.us 903-737-2411
Hospital Authority	177870603	14613532945000	Non-State Public	Fannin County Hospital Authority	David Conjeo	504 Lipscomb Blvd. Bonham, TX 75418 David.conjeo@RRRH-TX.com 903-583-8585
State Hospital	133331202	33201136430000	State Owned	Rusk State Hospital	Olga Rodriguez	1100 W 49th St Austin, TX 78756 Olga.Rodriguez@dshs.state.tx.us 512-776-7181
Performing Providers						
Academic Medical Center	127278302	17529317202000	State Owned	The University of Texas Health Science Center at Tyler – MSRDP (University Physician Associates)	Jeff Levin, MD, MSPH	11937 US Hwy 271 Tyler, Texas 75708 jeffrey.levin@uthct.edu 903-877-7270
Community Mental Health Center	137921608	17517240176003	Non-State Public	Community Healthcore	Rick Roberts	107 Woodbine Pl Longview, TX 75601 Rick.roberts@communityhealthcore.com 903-237-2338
Community Mental Health Center	138365512	17512814108000	Non-State Public	Andrews Center	Waymon Stewart	2323 West Front Street Tyler, TX 75702

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)
						wstewart@andrewscenter.com 903-597-1351
Private Hospital	139173209	17518545623001	Private	East Texas Medical Center Athens	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Private Hospital	094127002	17527350775000	Private	East Texas Medical Center – Carthage	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Public Hospital	130862905	17526380203002	Non-State Public	East Texas Medical Center – Clarksville	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Private Hospital	137319306	17526026210004	Private	East Texas Medical Center – Crockett	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Private Hospital	094190802	17527534543000	Private	East Texas Medical Center – Fairfield	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Public Hospital	208843701	12641237289000	Non-State Public	East Texas Medical Center Henderson	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Private Hospital	130612806	17527150845000	Private	East Texas Medical Center Jacksonville	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
						(903) 531-8010
Public Hospital	136140407	17522507304002	Non-State Public	East Texas Medical Center Mount Vernon	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Public Hospital	138374715	17519196244001	Non-State Public	East Texas Medical Center Pittsburg	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Public Hospital	017624002	17527661601006	Non-State Public	East Texas Medical Center – Quitman	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Private Hospital	121817401	17527158988003	Private	East Texas Medical Center Trinity	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Private Hospital	020812601	17518033257001	Private	East Texas Medical Center	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Private Hospital	168447401	12000791629002	Private	East Texas Medical Center Gilmer	Byron Hale, CFO ETMCRHS	1000 S. Beckham Ave, Tyler, TX 75701 P.O. Box 6400 (75711) Bhale@etmc.org (903) 531-8010
Public Hospital	1310385-04	17512772934501	Non-State Public	Hunt Regional Medical Center Greenville	Richard Carter	4215 Joe Ramsey Blvd Greenville, TX 75403-1059 rcarter@huntregional.org 903-408-1605

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)
Private Hospital	094108002	17508181678002	Private	Mother Frances Hospital	Mary Elizabeth Jackson	611 S Fleishel Tyler, TX 75701 jacksom@tmfhs.org 903-531-4788
Community Mental Health Center	136367307	17514423932000	Non-State Public	Burke Center	Susan Rushing	2001 S. Medford Drive Lufkin, TX 75901 SusanR@burke-center.org 936-633-5602
Public Hospital	131037704	17560018123000	Non-State Public	Hopkins County Memorial Hospital	Michael McAndrew	115 Airport Road Sulphur Springs, TX 75482 michaelm@hcmh.com 903-439-4051
Community Mental Health Center	121988304	17528338233000	Non-State Public	Lakes Regional MHMR Center	John Delaney	400 Airport Rd. Terrell, TX. 75160 johnd@lrmhmrc.org 972-388-2000 ext.1150
Local Public Health Department	140425362	17560022067001	Non-State Public	Paris-Lamar County Health Department	Gina Prestidge	740 SW 6th Street Paris, TX 75460 ginap@suddenlinkmail.com 903-785-4561
Community Mental Health Center	084434201	17514523608014	Non-State Public	Texoma Community Center	Sylvia Cave	P. O. Box 1087 Sherman, TX 75091 scave@mhmrst.org 903-267-9616
Public Hospital	138913209	17560039350000	Non-State Public	Titus Regional Medical Center	Terry Scoggin	2001 N. Jefferson Mount Pleasant, Texas 75455 Terry.Scoggin@titusregional.com 903-577-6066
Local Public Health	1383606-06	17522545445000	Non-State	Northeast	George T.	315 N Broadway, Ste 404

RHP Participant Type	**Texas Provider Identifier** (TPI)	**Texas Identification Number** (TIN)	**Ownership Type** (state owned, non-state public, private)	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information** (address, email, phone number)
Department			Public	Texas Public Health District	Roberts, Jr., FACHE	Tyler, TX 75702 groberts@netphd.org 903-535-0036
Private Hospital	094095902	17510411543015	Private	Good Shepherd Medical Center Longview	Pat Keel	700 E Marshall Longview, Texas 75601 pkeel@gsmc.org 903-315-1820
Public Hospital	177870603	14613532945000	Non-State Public	Red River Regional Hospital	David Conjeo	504 Lipscomb Blvd. Bonham, TX 75418 David.conjeo@RRRH-TX.com 903-583-8585
UC-only Hospitals						
Private Hospital	141858401	17519769305007	Private	Mother Frances Hospital Jacksonville	Mary Elizabeth Jackson	611 S Fleishel Tyler, TX 75701 jacksom@tmfhs.org 903-531-4788
Private Hospital	127301305	17527715696004	Private	Mother Frances Hospital Winnsboro	Mary Elizabeth Jackson	611 S Fleishel Tyler, TX 75701 jacksom@tmfhs.org 903-531-4788
Public Hospital	020927202	17512772934010	Non-State Public	Hunt Regional Community Hospital	Richard Carter	4215 Joe Ramsey Blvd Greenville, TX 75401 rcarter@huntregional.org 903-408-1605
Private Hospital	207311601	17510033149002	Private	Brim Healthcare of Texas, LLC dba Wadley	Rebecca Johnson	1000 Pine Street Texarkana, TX 75501 rjones@wadleyhealth.com 903-798-8871

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)
				Regional Medical Center		
Private Hospital	110839103	16217624200005	Private	Longview Regional Medical Center	Todd Johnson	2901 N Fourth St. Longview, TX 75605 Todd.johnson@longviewregional.com 903-232-3603
Private Hospital	020976901	17527968154015	Private	CHRISTUS St. Michael Health System	Glen Boles	2600 St. Michael Drive Texarkana, TX 75503 Glen.boles@christushealth.org 903-614-2007
Private Hospital	121816602	17427915255000	Private	Palestine Regional Medical Center	Christi Watkins	2900 S Loop 256 Palestine TX 75801 Christi.watkins@LPNT.net 903-731-2225
Academic Medical Center	127278304	17560013546000	State Owned	The University of Texas Health Science Center at Tyler – Hospital	Vernon Moore	11937 US Hwy 271 Tyler, Texas 75708 vernon.moore@uthct.edu 903-877-2831
Private Hospital	112667403	17509743518004	Private	Good Shepherd Medical Center Marshall	Pat Keel	700 E Marshall Longview, Texas 75601 pkeel@gsmc.org 903-315-1820
Public Hospital	133255305	12370332400005	Non-State Public	Atlanta Memorial Hospital	Sheila Robinson	1007 S William Atlanta, Texas 75551 sjrobinson@atlantamemorial.com 903-799-3000
Private Hospital	163111101	13310739480000	Private	Paris Regional Medical Center	Ken Miller	820 Clarksville Paris, Texas 75460

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)
						Ken.miller@parisrmc.com 903-785-4521
State Hospital	133331202	33201136430000	State Owned	Rusk State Hospital	Olga Rodriguez	1100 W 49th St. Austin, TX 78756 Olga.Rodriguez@dshs.state.tx.us 512-776-7181
Other Stakeholders						
County Medical Associations/Societies						
County Medical Associations/Societies						
Regional Public Health Directors				Department of State Health Services, Region 4/5N	Dr. Paul McGaha	1517 W Front St. Tyler, Texas 75702 Paul.McGaha@dshs.state.tx.us 903-533-5264
Other significant safety net providers within the region (specify type)						
Others (specify type, e.g. advocacy groups, associations)						

Section II. Executive Overview of RHP Plan

A. RHP Goals and Vision

The Texas Healthcare Transformation and Quality Improvement Program (Demonstration) is designed to encourage "activities that support hospitals' collaborative efforts to improve access to care and the health of the patients and families they serve."[1] Consistent with that goal, the overarching goal and vision of the Northeast Texas Regional Healthcare Partnership (RHP 1) is to move toward a realization of the triple aim[2]:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations; and
- Reducing the per capita cost of health care.

In addition, addressing gaps in access to care (both physical and behavioral health services) is a key focus of the regional healthcare partnership.

B. Summary of Existing Healthcare Environment

Geographically, the Northeast Texas Regional Healthcare Partnership (RHP 1) spans 28 counties and borders three states. At 21,000 square miles, Region 1 is larger than nine states and the District of Columbia and is nearly 250 miles from point-to-point. Over 1.2 million people live in Northeast Texas, but there is no city with a population greater than 100,000. Approximately 54% of the regional population is either uninsured or enrolled in some form of publicly funded health coverage.

Northeast Texas is an area where patients face many challenges in accessing primary care, acute care, and mental and behavioral health services. Key health challenges include high numbers of medically underserved areas/populations, health professional shortages in primary care and mental health, lack of sufficient specialists to serve the patient population, high chronic disease burden, and high rates of potentially preventable hospitalization. Taken as a whole, Northeast Texas is older, poorer, and less well educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

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[1] Centers for Medicare and Medicaid Services: Texas Healthcare Transformation and Quality Improvement Program Standard Terms and Conditions. Washington, DC. U.S. Department of Health & Human Services (December 2011).

[2] Institute for Healthcare Improvement. (2012, October). *The IHI Triple Aim.* Retrieved October 2012 from Institute for Healthcare Improvement: http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

Six major community needs are identified in the regional health plan:

- CN.1: Insufficient access to primary and specialty care services
- CN.2: Insufficient access to mental and behavioral health services
- CN.3: High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
- CN.4: High costs due to potentially preventable hospitalizations.
- CN.5: Inappropriate emergency room utilization.
- CN.6: Efficiency in and effectiveness of health care delivery.

C. Realizing the Vision

Addressing these community needs is a priority for the region. As a result, the delivery system reform projects developed by the regional healthcare partnership show an integration of individual community needs, with many projects addressing multiple community needs. The clear focus of the region is on expanding access to care – both physical and mental/behavioral health care services.

The table below shows a summary of projects that, together, realize the regional vision:

Summary of Categories 1-2 Projects

Project Title (include unique RHP project ID number for each project.)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Category 1: Infrastructure Development			
017624002.1.1 Expand Existing Primary Care Capacity (ETMC Quitman 017624002)	Improve access to primary care.	017624002.3.1 IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate	$2,059,983
020812601.1.1 Expand Specialty Care Capacity (ETMC Tyler 020812601)	Improve access to specialty care	020812601.3.1 IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)233-NQF 0059	$3,802,962
020812601.1.2 Expand Specialty Care Capacity (ETMC Tyler 020812601)	Improve access to specialty care	020812601.3.2 IT-3.2 CHF 30-Day Readmission Rate	$6,220,179

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**
020812601.1.3 Expand Specialty Care Capacity (ETMC Tyler 020812601)	Improve access to specialty care	020812601.3.3 IT-1.18 Follow-Up After Hospitalization for Mental Illness - NQF 0576236	$3,254,790
084434201.1.1 Expand Telehealth Services (Texoma Community Center 084434201)	The project seeks to develop, enhance and promote telemedicine and telehealth protocols and practices to improve access to care and expand the overall population served.	084434201.3.1 IT-10.1 Quality of Life	$199,496
084434201.1.2 Develop Substance Abuse Services (Texoma Community Center 084434201)	The project seeks to develop and implement comprehensive outpatient substance abuse program to expand access to care within the community and reduce unnecessary hospitalizations.	084434201.3.2 IT-10.1 Quality of Life	$166,746
084434201.1.3 Enhance Service Availability (Texoma Community Center 084434201)	The project seeks to develop and enhance counseling services within the community and expand access to unfunded and underserved individuals	084434201.3.3 IT-10.1 Quality of Life	$265,192
084434201.1.4 Expand Quality Improvement Capacity (Texoma Community Center 084434201)	The project seeks to implement process improvement methodologies to enhance safety, quality and efficiency in overall healthcare service provision while maintaining excellent quality of care standards	084434201.3.4 IT-9.2 ED Appropriate Utilization	$80,762
094108002.1.1 Expand Primary Care Capacity (Mother Frances Hospital 094108002)	Access to primary care providers will be addressed by recruiting and establishing a minimum of 7 new practices. They will be in rural and urban setting and will expand existing clinics and hours. Targeted populations are Medicaid, Medicare, and uninsured but all payers will have access. Patient visits will be counted.	094108002.3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$11,692,599
094108002.1.2 Expand Specialty Care Capacity (Mother Frances Hospital 094108002)	Expansion of specialty will result in a minimum of 7 new providers serving the urban and rural areas for special clinics. They will also provide services for the ER, as appropriate, inpatient needs, and outpatient services. Patient visits will be counted as well as implementing a referral management system.	094108002.3.2 IT-3.1 All cause 30 day readmission rate- NQF 1789	$17,538,898
094108002.1.3 Introduce, Expand, or Enhance Telemedicine/Telehealth (Mother Frances Hospital 094108002)	The goal of this project is to expand and enhance the capacity of providers in the region to manage complex pediatric patients locally through timely access to pediatric subspecialists and specialists via telemedicine.	094108002.3.4 IT-9.2 ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)	$3,581,145

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**
094127002.1.1 Expand Primary Care Capacity (ETMC Carthage 094127002)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 094127002.3.1	$1,508,923
094190802.1.1 Expand Primary Care Capacity (ETMC Fairfield 094190802)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 094190802.3.1	$439,819
21817401.1.1 Expand Primary Care Capacity (ETMC Trinity 121817401)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 121817401.3.1	$1,698,431
121988304.1.1 Depression/Trauma Counseling Centers (Lakes Regional MHMR Center 12988304)	Expand number of community based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression / Trauma Counseling Centers)	121988308.3.1 IT-10.1 Quality of Life	$4,268,280
127278302.1.1 Increase, Expand and Enhance Oral Health Preventive Services (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Collaboration between University Physician Associates and Tyler Junior College to enhance dental preventive services and train dental hygiene students	127278302.3.1 – IT-7.8 Chronic Disease Patients Accessing Dental Services	$5,444,794
127278302.1.9 Pass 3b (127278302.1.2) Improve Access to Specialty Care for UPA (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Expand selective specialty care services for referral from the PCMH to include podiatry, neurology/pain, ophthalmology, infectious diseases, dermatology, rheumatology and endocrinology	127278302.3.32 Pass 3b (127278302.3.2) –IT-1.12 Diabetes care: Retinal eye exam 127278302.3.33 Pass 3b (127278302.3.3) –IT-1.13 Diabetes care: Foot exam 127278302.3.4 Pass 3b (127278302.3.4) –IT-1.14 Diabetes care: Microalbumin/Neuropathy	$9,172,037
127278302.1.10 Pass 3b (127278302.1.3) Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavioral Health	Collaboration between University Physician Associates, Good Shepherd Medical Center and Palestine Regional Medical Center to increase access to integrated primary and behavioral health care services along with specialty consultation by psychiatry	127278302.3.35 Pass 3b (127278302.3.5) – IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as	$3,660,478

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**
Services in Northeast Texas (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)		jails or prisons	
127278302.1.4 Increase Training of Primary Care Workforce: Capacity Building Through Workforce Development: Training Community Health Workers (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Establish CHW certification programs with specialty tracks for chronic disease self-management, behavioral health, and tele-health facilitation.	127278302.3.6 – IT-9.4 "Other" Increase Number of DSHS certified CHWs	$4,117,353
127278302.1.11 Pass 3b (127278302.1.5) Expand Primary Care Capacity (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	With Christus St. Michael Health System, increase primary care capacity by increasing the number of primary care clinic appointments available to the low-income members of the community and in doing so, creating more access.	127278302.3.36 Pass 3b (127278302.3.7) – IT-2.11 Ambulatory care sensitive conditions admissions rate	$4,909,364
127278302.1.12 Pass 3b (127278302.1.6) Expand Dental Services (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	With Christus St. Michael Health System, expand services to five groups that are underserved with regard to dental health problems serving as the foundation that will allow a more appropriate setting for expanded dental health service for the identified 'at-risk' population.	127278302.3.37 Pass 3b (127278302.3.8) – IT-7.10 "Other" Decrease the percentage emergency department visits for dental care	$4,657,980
127278302.1.13 Pass 3b (127278302.1.7) Crisis Stabilization Unit (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Palestine Regional Medical Center will partner with UPA to establish a crisis stabilization unit for behavioral health care	127278302.3.38 Pass 3b (127278302.3.9) – IT-9.2 Reduce inappropriate ED utilization	$2,876,901
127278302.1.8 Expand Primary Care - North Tyler Clinic (UTHSCT MSRDP - University Physician Associates (UPA)	Increase access to a poor, largely minority, underserved area of Smith County by establishing an open access clinic within the community to provide basis care services and a referral channel to patient centered medical homes and specialty providers.	127278302.3.28 – IT-11.1 Improvement in Clinical Indicator in identified disparity group 127278302.3.29 – IT-12.5	$9,349,243

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127278302)		Other USPSTF-endorsed screening outcome measures	
130612806.1.1 Expand Primary Care Capacity (ETMC Jacksonville 130612806)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 130612806.3.1	$2,259,975
130862905.1.1 Expand Primary Care Capacity (ETMC Clarksville 130862905)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 130862905.3.1	$2,031,562
131037704.1.1 Expand Primary Care Capacity (Hopkins County Memorial Hospital 131037704)	Expand existing primary care capacity	131037704.3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$2,903,771
131037704.1.2 Expand primary care capacity (Hopkins County Memorial Hospital 131037704)	Expand existing primary care capcity	131037704.3.3 IT-9.4 Other Outcome Improvements	$458,098
131038504.1.1 Expand Primary Care Capacity (Hunt Regional Medical Center Greenville, 131038504)	Partner with Community Health Service Agency (FQHC) to increase primary care providers, clinic hours, availability of urgent visits and add a clinic in Southern Hunt County.	131038504.3.1 IT-1.6 Cholesterol management for patients with cardiovascular conditions	$6,204,273
131038504.1.2 Introduce, Expand or Enhance Telehealth (Hunt Regional Medical Center Greenville, 131038504)	This project will implement telehealth to provide remote patient monitoring and outpatient disease management to congestive heart failure patients in the home setting.	131038504.3.4 IT-3.2 Congestive Heart Failure 30 day Readmission Rate	$1,377,015
131038504.1.3 Enhance Performance Improvement and Reporting Capacity (Hunt Regional Medical Center Greenville, 131038504)	Hunt Regional Medical Center will implement a project to enhance performance improvement and reporting capacity through people, processes and technology. We will hire two additional quality analysts to collect, analyze and perform performance improvement, purchase and install a data repository and interface to collect real-time data, develop a quality dashboard to measure improvement and select quality indicators including potentially preventable complications for rapid improvement.	131038504.3.5 IT-4.1 Improvement in risk adjusted potentially preventable complications rates	$932,910

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136140407.1.1 Expand Primary Care Capacity (ETMC Mt. Vernon 136140407)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 136140407.3.1	$470,780
136367307.1.1 Enhance Service Availability of Appropriate Levels of Behavioral Health Care (Burke Center 136367307)	This project will expand the capacity of the Burke Center to serve more children and adults with mental illness. We will provide outpatient psychiatric care, therapy, medication services and patient education as needed.	136367307.3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$1,251,859
137319306.1.1 Expand Primary Care Capacity (ETMC Crockett 137319306)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 137319306.3.1	$1,682,012
137921608.1.1 1.13.1 -Development of behavioral health crisis stabilization services as alternatives to hospitalization (Community Healthcore 137921608)	Evidence based crisis intervention/stabilization and detox center for behavioral health with early intervention and intensive wrap around services in the **Northern** portion of Region 1.	137921608.3.1 IT-9.2 ED appropriate utilization	$12,907,183
137921608.1.2 1.13.1 -Development of behavioral health crisis stabilization services as alternatives to hospitalization (Community Healthcore 137921608)	Evidence based crisis intervention/stabilization and detox center for behavioral health with early intervention and intensive wrap around services in the **Southern** portion of Region 1.	137921608.3.2 IT-9.2 ED appropriate utilization	$11,936,797
137921608.1.3 1.9.2 Improve access to specialty care (Community Healthcore 137921608)	Community Healthcore will operate an ambulatory detoxification clinic in a non-residential setting co-located with the University of Texas Health Science Center-Tyler primary care clinic. The program will provide a safe withdrawal from the drug(s) of dependence and enable the individual to become drug free through a medical model program.	137921608.3.3 IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate	$2,079,217
138374715.1.1 Expand Specialty Care Capacity ETMC Pittsburg 138374715)	Improve access to specialty care	IT-4.4 Surgical Site Infection (SSI) Rates 138374715.3.1	$4,310,504
138365512.1.1 Crisis Intervention (Andrews Center 138365512)	Development of behavioral health crisis stabilization center as alternative to hospitalization	138365512.3.1 IT-9.2 ED Appropriate Utilization	$3,475,052

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138913209.1.1 Expand Primary Care Capacity (Titus Regional Medical Center 138913209)	Establish more primary care clinics. TRMC plans to build a new Family Care Center in an underserved location of the city.	138913209.3.1 – IT-6.1 – Percent Improvement Over Baseline of Patient Satisfaction Scores 138913209.3.2 – IT-9.2 - ED Appropriate Utilization	$4,365,952
138913209.1.2 Expand Specialty Care Capacity (Titus Regional Medical Center 138913209)	Improve access to specialty care.	138913209.3.4 – IT-3.3 – Diabetes 30 day readmission rate	$545,851
138913209.1.3 (Pass 3B) Expand high impact specialty care capacity in most impacted medical specialties (Titus Regional Medical Center 138913209)	Increases the capacity of specialty healthcare in Northeast Texas through TRMC achieving the Texas certification as a Level II Primary Stroke Center and the recruitment of a full time neurologist to establish a specialty clinic location.	138913209.3.6 IT-3.7 Stroke CVA 30 day readmission rate	$3,111,106
139173209.1.1 Expand Primary Care Capacity (ETMC Athens 139173209)	Establish more primary care clinics	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 139173209.3.1	$3,096,915
139173209.1.2 Expand Primary Care Capacity (ETMC Athens 139173209)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 139173209.3.2	$6,468,296
140425362.1.1 Expand Existing Primary Care Capacity (Paris-Lamar County Health Department 1404253)	The goal of this project is to expand the capacity of preventive and primary care services to better accommodate the needs of the patient population and community so that patients can receive the right care at the right time in the right setting.	140425362.3.1 IT 6.1 Percent Improvement over baseline of patient satisfaction scores	$1,331,250
168447401.1.1 Expand Primary Care (ETMC Gilmer 168447401)	Expand existing primary care capacity	168447401.3.1 IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate	$1,597,797
177870603.1.1 Expand existing primary care capacity (Red River Regional Hospital 177870603)	Expand primary care capacity through extended clinic hours, recruiting a family practice physician and a physician assistant, and adding needed support staff	177870603.3.1 IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate	$2,196,871

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208843701.1.1 Expand Primary Care Capacity (ETMC Henderson 208843701)	Expand existing primary care capacity	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 208843701.3.1	$515,225
208843701.1.2 Expand Specialty Care Capacity (ETMC Henderson 208843701)	Improve access to specialty care	IT-4.4 Surgical Site Infection (SSI) Rates 208843701.3.2	$2,060,899
Category 2: Program Innovation and Redesign			
020812601.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Tyler 020812601)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 020812601.3.4	$4,048,877
020812601.2.2 Implement/Expand Care Transitions Program (ETMC Tyler 020812601)	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions.	IT-3.2 CHF 30-Day Readmission Rate 020812601.3.5	$1,918,723
020812601.2.3 Redesign to Improve Patient Experience (ETMC Tyler 020812601)	Implement processes to measure and improve patient experience.	IT-6.1 % Improvement Over Baseline Patient Sat Scores 020812601.3.6	$6,663,389
084434201.2.1 Combine Primary and Behavioral Healthcare (Texoma Community Center 084434201)	The project seeks to combine primary and behavioral health care for over-utilizers of local health care resources and those within the community who are underserved or poorly served.	084434201.3.5 IT-10.1 Quality of Life	$248,781
084434201.2.2 Expand Community Based Interventions for Targeted Behavioral Health Population (Texoma Community Center 084434201)	The project will provide specialized services to complex behavioral health populations, with severe mental illnesses and/or a combination of behavioral and physical health issues in order to avert potentially avoidable inpatient admissions and readmissions to a more restrictive and expensive setting such as acute and/or psychiatric hospitals or the criminal justice system	084434201.3.6 IT-9.2 ED Appropriate Utilization	$80,248
094095902.2.1 – Establish/Expand a Patient Care Navigation Program (Good Shepherd Medical Center Longview 094095902)	Good Shepherd Medical Center (GSMC) will identify frequent ED users and use navigators as part of a preventable ED reduction program collaborating with Community Healthcore lead agency for the East Texas Aging Disability Resource Center and through the network will liaison with other community resources to address non-medical needs.	094095902.3.1 – IT-9.2 ED Appropriate Utilization.	$1,981,138

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**
094108002.2.1 Redesign for Cost Containment (Mother Frances Hospital 094108002)	A new cost accounting system will be implemented as part of a clinic transformation process.	094108002.3.3 IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery	$9,743,833
094108002.2.2 Establish/Expand A Patient Care Navigation Program (Mother Frances Hospital 094108002)	This project will implement a patient navigator dedicated to the Ross Breast Center that will guide newly diagnosed patients with breast cancer. The interventions will include but not be limited to referral to primary care medical home, specialty care referral for disenfranchised or medically complex patients , and education on appropriate level of care needed and medical instructions, and follow-up with patients.	094108002.3.5 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$1,432,458
094108002.2.3 Implement/Expand Care Transitions Programs (Mother Frances Hospital 094109002)	The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute, and home care settings in order to prevent increased health care costs and hospital readmissions.	094108002.3.6 IT-3.1 All cause-90 day readmission rate- NQF 1789	$1,432,458
094127002.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Carthage 094127002)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 094127002.3.2	$1,216,305
094190802.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Fairfield 094190802)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 094190802.3.2	$761,721
121817401.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Trinity 121817401)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 121817401.3.2	$1,096,392
121988304.2.1 Integrated Primary Care/Behavioral Health Mobile Clinic (Lakes Regional MHMR Center 12988304)	Design, implement and evaluate projects that provide integrated primary and behavioral health care services: (Lakes Regional Care Integration Project)	121988304.3.2 IT-6.1 Patient Satisfaction	$3,438,954
121988304.2.2 Physical wellness/Health Mentor program for a targeted behavioral health population. (Lakes	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: (Lakes Regional IN-SHAPE Program)	121988304.3.3 IT-6.1 Patient Satisfaction	$641,676

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Regional MHMR Center 12988304)			
127278302.2.1 Enhance/Expand Medical Homes for UPA Primary Care Clinics (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Implement PCMH; expand primary care capacity; implement CHW chronic disease self-management, behavioral health, and tele-health facilitation.	127278302.3.10 – IT- 12.3 Colorectal cancer screening 127278302.3.11 – IT-12.4 Pneumonia vaccination status for older adults 127278302.3.12 IT-12.5 "Other" USPSTF-endorsed screening outcome measure	$7,522,339
127278302.2.14 Pass 3b (127278302.2.2) Enhance/Expand Medical Homes for GSMC Internal Medicine Residency Clinic (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Collaboration between University Physician Associates and Good Shepherd Medical Center to implement PCMH; expand primary care capacity; implement CHW chronic disease self-management, behavioral health, and tele-health facilitation.	127278302.3.39 Pass 3b (127278302.3.13) – IT-12.3 Colorectal cancer screening 127278302.3.40 Pass 3b (127278302.3.14) – IT-12.4 Pneumonia vaccination status for older adults 127278302.3.41 Pass 3b (127278302.3.15) –IT-12.5 Other USPSTF-endorsed screening outcome measure	$7,347,539
127278302.2.15 Pass 3b (127278302.2.3) Use of Palliative Care Programs: Supportive Care for Patients with Debilitating Diseases (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Collaboration between University Physician Associates and Good Shepherd Medical Center where supportive care teams will use evidence-based models of effective advance care planning for patients with chronic, debilitating diseases to implement palliative care, reduce unnecessary ED visits and hospitalizations.	127278302.3.42 Pass 3b (127278302.3.16) –IT-13.1 Percent improvement in pain assessment (NQF-1637) 127278302.3.43 Pass 3b (127278302.3.17) – IT-13.2 Percent improvement in treatment preferences (NQF-1641) 127278302.3.44 Pass 3b (127278302.3.18) – IT-13.5 Percent improvement in	$8,735,499

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**
		discussion of spiritual/religious concerns (NQF-1647 modified)	
127278302.2.16 Pass 3b (127278302.2.4) Improve Self-Management for Pediatric Asthma Patients (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Collaboration between University Physician Associates, Christus St. Michael Health System and local independent school districts to deploy mobile units to facilitate early diagnosis and disease management for children with asthma throughout the region.	127278302.3.45 Pass 3b (127278303.3.19) – IT.6.1 Patient Satisfaction – percent improvement over baseline of patient satisfaction scores	$9,352,872
127278302.2.5 Evidence-based Disease Prevention: Expand Delivery of Early Colon Cancer Treatment and Secondary Prevention Management (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Increase access to colon cancer specialty management (gastroenterology/medical oncology/surgical oncology) via the PCMH and utilize CHWs for a widespread community outreach and education campaign.	127278302.3.20 – IT-6.1 Patient Satisfaction – percent improvement over baseline of patient satisfaction scores	$9,166,982
127278302.2.17 Pass 3b (127278302.2.6) Apply a Systematic Approach to Improve Quality/ Efficiency for CHF Patients (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Through a collaboration facilitated by University Physician Associates, Palestine Regional Medical Center, Good Shepherd Medical Center, and Christus St. Michael Health System will use a learning collaborative format to select, implement and evaluate QI/E processes and meet regularly to share challenges, successes, lessons learned, and establish a compendium of best practices.	127278302.3.46 Pass 3b (127278302.3.21) – IT-3.2 Congestive heart failure 30 day readmission rate	$6,747,683
127278302.2.18 Pass 3b (127278302.2.7) Integrate Primary and Behavioral Health Care Services (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Through collaboration between University Physician Associates and Good Shepherd Medical Center, behavioral health professionals and CHWs will be added to primary care teams to foster integration of behavioral health services for patients in the primary care setting.	127278302.3.47 Pass 3b (127278302.3.22) – IT-1.8 Depression management: screening & treatment plan for clinical depression 127278302.3.48 Pass 3b (127278303.3.23) – IT-1.9 Depression management: remission at twelve months	$10,552,740

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127278302.2.19 Pass 3b (127278302.2.8) Implement Patient Care Navigator and CHW chronic disease self-management program to reduce emergency department visits (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Train and deploy Patient Care Navigators to facilitate hospital discharge and partner with the PCMH team to prevent hospital admissions/readmissions.	127278302.3.49 Pass 3b (127278302.3.24) –IT- 9.2 ED Appropriate Utilization	$10,040,236
127278302.2.20 Pass 3b 127278302.2.9 Enhance Medical Home (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	Create a partnership between Christus St. Michael Health System and a medical home that initiatives preventive care and reduces reliance on Emergency Departments for primary care.	127278302.3.50 Pass 3b (127278302.3.25) – IT 3.1 All cause 30 day readmission rate	$4,983,301
127278302.2.22 Pass 3b (127278302.2.11) – Expand Care Transition Programs (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	With Christus St. Michaels, create smooth transitions of care from inpatient to outpatient settings, alternative inpatient settings, or home care so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions.	127278302.3.52 Pass 3b (127278302.3.27) – IT-3.2 Congestive Heart Failure 30 day readmission rate	$4,865,003
127278302.2.23 Pass 3b (127278302.2.12) – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)	With Palestine Regional Medical Center, develop an intensive outpatient behavioral health therapy program to continue care for adult behavioral health patients after completing the existing inpatient programs or for patients leaving the crisis stabilization unit that do not meet inpatient criteria and patients requiring behavioral health therapy in order to avoid crisis situations.	127278302.3.53 Pass 3b (127278302.3.30) – IT-9.2 ED appropriate utilization	$1,438,451
127278302.2.13 – Implement evidence-based strategies to reduce and prevent obesity in	Extend the evidence-based, multi-disciplinary pediatric weight management program from the Center for Obesity and it's Complications on Health (COACH) at Children's Medical Center in Dallas to a rural county in Northeast Texas (Lamar)	127278302.3.31 – IT-10.1 Percent improvement over baseline of patient quality of life	$814,410

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children and adolescents (UTHSCT MSRDP - University Physician Associates (UPA) 127278302)			
130612806.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Jacksonville 130612806)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 130612806.3.2	$1,586,215
130862905.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Clarksville 130862905)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 130862905.3.2	$855,372
131037704.2.1 Implement and innovative and evidence based intervention that will lead to cost savings for providers that have demonstrated need or unsatisfactory performance in this area (Hopkins County Memorial Hospital 131037704)	Implement a cost account system to identify unique and specific costs of providing care for the top 25 DRGs by volume.	131037704.3.2 IT-5.1 Cost of Care	$2,587,195
131037704.2.2 Develop, implement, and evaluate standardized clinical protocols and evidence based delivery models to improve care transitions (Hopkins County Memorial Hospital 131037704)	Develop, implement, and evaluate standardized clinical protocols and evidence based care delivery models to improve care transitions focusing on congestive heart failure patients.	131037704.3.4 IT 3.2 Congestive Heart Failure 30 day Readmission Rate	$519,527
131038504.2.1 Establish/Expand a Patient Care Navigation Program (Hunt Regional Medical Center Greenville 131038504)	Implement a patient navigation program to make home visits to ED superuser patients and provide intense case management to high medical and social need patients including: medication management, implementing evidence based care plans, coordination of primary and specialty care visits, communicate health information to providers, provide patient/family self-management tools and disease education, conduct telephone follow-up and assist patients connect with outpatient resources.	131038504.3.2 IT- 9.2 ED Appropriate Utilization	$8,005,515

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**
1310385-04.2.2 Implement/Expand Care Transitions Programs (Hunt Regional Medical Center Greenville 1310385-04)	Implementation of Project RED, a comprehensive, standardized discharge program that implements best practices to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates.	131038504.3.3 IT- 3.1 All cause 30 day readmission rate	$2,301,586
136140407.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Mt. Vernon 136140407)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 136140407.3.2	$430,331
137319306.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Crockett 137319306)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 137319306.3.2	$1,849,399
137921608.2.1 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. (Community Healthcore 137921608)	Community Healthcore will collaborate with Good Shepherd Medical Center and the local FQHC in the Longview area to integrate primary and behavioral healthcare services to result in an integrated approach to health care that is "More Than Co-Location."	IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)228 IT-1.11 Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061	$558,137
138360606.2.1 Center for Healthy Living (Northeast Texas Public Health District 1383606-06)	The Center for Healthy Living will focus on improving the quality of life of citizens of Tyler. The Center will establish self-management and wellness programs using evidence – based practices. Self- management programs will include: diabetic management classes and Screenings such as mobile mammography, blood pressure, blood glucose, cholesterol, weight and BMI will be provided	138360606.3.1, IT-10.1, Quality of Life	$532,000
138365512.2.1 Jail Diversion (Andrews Center 138365512)	Intercept behavioral health patients from several points within the justice system	138365512.3.2 IT-9.1 Decrease in mental health admissions to criminal justice settings	$2,895,877
138365512.2.2 Primary Behavioral Health Integration (Andrews Center 138365512)	Provide integrated primary and behavioral health services through clinic hours	138365512.3.3 IT-9.2 ED Appropriate Utilization	$5,212,579

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**
138365512.2.3 Outpatient Therapy Expansion (Andrews Center 138365512)	Increase therapy services in Smith, Henderson, Van Zandt, Wood, and Rains counties by expanding an intensive therapy program for the behavioral health population	138365512.3.4 IT-9.2 ED Appropriate Utilization	$967,322
138913209.2.1 Redesign for Cost Containment (Titus Regional Medical Center 138913209)	Develop a Business Intelligence system with the capability to test methodologies for measuring cost containment, intervention and innovation impacts so they may be applied to other projects or efforts giving Titus Regional Medical Center the ability to measure the efficiency of these initiatives and expand the ability to generate data reports to prioritize our decisions for improvement initiatives.	138913209.3.3 – IT-5.2 – Per Episode Cost of Care	$2,182,976
138913209.2.2 Redesign to Improve Patient Experience (Titus Regional Medical Center 138913209)	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.	138913209.3.5 – IT-6.1 – Percent Improvement Over Baseline of Patient Satisfaction Scores (1) Are getting timely care, appointments and information	$482,228
139173209.2.1 Establish/Expand a Patient Care Navigation Program (ETMC Athens 139173209)	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.	IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate 139173209.3.3	$3,951,048
139173209.2.2 Implement/Expand Care Transitions Program (ETMC Athens 139173209)	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions.	IT-3.2 CHF 30-Day Readmission Rate 139173209.3.4	$875,255
139173209.2.3 Redesign to Improve Patient Experience (ETMC Athens 139173209)	Implement processes to measure and improve patient experience.	IT-6.1 % Improvement Over Baseline Patient Sat Scores 139173209.3.5	$2,005,823
177870603.2.1 Establish self-management program (Red River Regional Hospital 177870603)	Implement an evidence-based diabetes management program	177870603.3.2 IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$817,813
177870603.2.2 Implement processes to improve patient experience (Red River Regional Hospital 177870603)	Develop and implement a patient experience improvement plan in order to improve how the patient experiences care	177870603.3.3 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$930,062

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**
177870603.2.3 Interventions tailored towards geriatric, behavioral health patients (Red River Regional Hospital 177870603)	Provide a structured outpatient program (SOP) for geriatric, behavioral health patients	177870603.3.4 IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate	$144,399

The following projects were previously included in the *Summary of Category 1-2 Projects* table but were removed from the regional health plan:

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**
Removed during Pass 3B: 12728302.2.10 Apply Process Improvement Methodology to Improve Quality/Efficiency (UTHSCT MSRDP – University Physician Associates (UPA) 12728302)	With Christus St. Michael Health System, reduce harm or death to patients seeking care due to sepsis by following the Institute for Healthcare Improvement recommended Surviving Sepsis Campaign while supporting an interdisciplinary team approach.	12728302.3.26 IT-4.8 Sepsis Mortality	$6,117,377
Removed by Performing Provider: 218834401.2.1 Implement Palliative Care Program (Texas Palliative Care 218834401)	Expand palliative care consulting program to help hospital patients with end-of-life-decisions.	218834401.3.1 IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)	$1,230,304

Section III. Community Needs Assessment

This community needs assessment draws from data collected from federal and state governmental agencies, academic studies, and local providers. The 2012 *County Health Rankings* report from the University of Wisconsin and the Robert Wood Johnson Foundation and data from the Texas Department of State Health Services' 2007 *East Texas Community Health Needs Assessment* (ETCHNA) were particularly useful to the development of this community needs assessment because accurate data collection can be difficult in rural areas of the state. The ETCHNA report, included in the addendum to the regional health plan, represents a major effort to document the health issues in our region and includes data from 1,924 individuals who completed a survey, 470 individuals who attended a community forum, and available demographic and epidemiological data[3]. Additional data were gathered from the US Census Bureau, the Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services. When necessary, these major data sources were supplemented with provider data.

The health needs in Northeast Texas are great, but this community needs assessment is intended to highlight the region's most pressing needs. Performing providers selected projects that address regional needs and included data specific to the populations served by their delivery system reform projects in the actual narratives of those projects.

A. Executive Summary

Geographically, the Northeast Texas Regional Healthcare Partnership (RHP 1) spans 28 counties and borders three states. At 21,000 square miles, Region 1 is larger than nine states and the District of Columbia and is nearly 250 miles from point-to-point. Over 1.2 million people live in Northeast Texas, but there is no city with a population greater than 100,000.

Northeast Texas is an area where patients face many challenges in accessing primary care, acute care, and mental and behavioral health services. Below are key health challenges in Northeast Texas:

[3] Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.

- **Medically Underserved Areas/Populations:** All but three counties in Region 1 are either wholly designated as Medically Underserved Areas/Populations (MUA/P) or have service areas within the county that are designated as MUA/P.[4]

- **Primary Medical Care Health Professional Shortage Areas:** 89.3% of counties in Region 1 have shortages in primary care professionals[5]. In some counties, the ratio of patients to primary care providers is five times the statewide average and nearly eight times the national benchmark.[6]

- **Mental/Behavioral Health Professional Shortage Areas:** Over 85% of counties in Northeast Texas have a shortage of mental health providers.[7] The ratio of patients to mental health providers in some communities of Northeast Texas is nearly 25,000 to one, seven times the state average.[8]

- **Health Factors & Outcomes:** Over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes and over one third are in the bottom quartile of Texas counties in health factors.[9]

- **High Chronic Disease Burden:** The region has higher rates of high blood pressure, lower rates of cholesterol screening,[10] and higher age-adjusted invasive cancer incidence and mortality rates than the state average.[11]

- **High Rates of Potentially Preventable Hospitalizations:** The majority of counties in Region 1 have higher rates of potentially preventable hospitalizations than the state average.[12]

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[4] U.S. Department of Health and Human Services. (2012, October). *Find Shortage Areas: MUA/P by State and County*. Retrieved October 2012, from Health Resources and Services Administration: http://muafind.hrsa.gov/

[5] U.S. Department of Health and Human Services. (2012, October). *Find Shortage Areas: HPSA by State & County*. Retrieved October 2012, from Health Resources and Services Administration: http://hpsafind.hrsa.gov/

[6] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org.

[7] U.S. Department of Health and Human Services. (2012, October). *Find Shortage Areas: HPSA by State & County*. Retrieved October 2012, from Health Resources and Services Administration: http://hpsafind.hrsa.gov/

[8] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org.

[9] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org.

[10] Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.

[11] Texas Department of State Health Services. *Age Adjusted Invasive Cancer Incidence Rates in Texas, All Sites, 2005-2009.*

[12] Texas Department of State Health Services. (2012, October). *Preventable Hospitalizations - County Profiles*. Retrieved October 2012, from Texas Department of State Health Services: http://www.dshs.state.tx.us/ph/county.shtm

After considering the data available to the region, stakeholders agreed that the following six community needs represent the most pressing needs in Northeast Texas:

Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1	Insufficient access to primary and specialty health care services.	*2012 County Health Rankings; Health Resources & Services Administration (US Dept. of Health & Human Services).*
CN.2	Insufficient access to mental and behavioral health services.	*Health Resources & Services Administration (US Department of Health & Human Services); Texas Department of State Health Services; Provider data.*
CN.3	High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.	*Texas Department of State Health Services; 2012 Cancer Registry*
CN.4	High costs due to potentially preventable hospitalizations.	*Texas Department of State Health Services.*
CN.5	Inappropriate emergency department utilization.	*National Institute for Health Care Reform*
CN.6	Efficiency in and effectiveness of health care delivery.	*Centers for Medicare and Medicaid Services*

These community needs, while shown as six distinct needs, are interrelated. Access to care, for example, impacts rates for chronic disease, potentially preventable hospitalizations, emergency room utilization, and the overall efficiency in and effectiveness of our health care delivery system. As a result, the delivery system reform projects developed by the regional health partnership show an integration of individual community needs, with many projects addressing multiple community needs.

The following subsections will address demographic and healthcare related data specific to Northeast Texas.

B. Demographics

This section highlights basic demographic data for Region 1, including population, insurance coverage status, age, race/ethnicity/language, income, education, employment, and poverty. Demographic data is important to understanding the full array of factors contributing to disease and health.

Region 1 and Texas

Table 1: Demographic Summary

	RHP 1	Texas
Population	1,289,873	25,145,561
Median Age	41	33.6
Per Capita Income	$19,386	$24,870
Bachelor's Degree or Higher	13.2%	25.8%
Minority Population	24.8%	29.6%
Percentage Hispanic/Latino Origin	13.1%	37.6%
Percentage Living in Rural Area	53.9%	17.5%

Table 1 above shows a comparison of high-level demographic data for Region 1 compared with statewide averages. Region 1 represents slightly more than five percent of the state's total population but is older, poorer, and is less well educated that the state average. While the overall minority population is comparable to the state average, only 13.1% of the region's population identifies as Hispanic or Latino origin, compared to a state average of 37.6%. Over half of the region's population lives in a rural area, compared to less than one fifth of the state's population.

Various sources were used to determine health insurance coverage status, many of which rely on estimates. In addition, US Census Bureau data were unavailable for some rural counties, which further complicates estimations of private health insurance coverage. Table 2 reports available data on health insurance coverage types by county in Region 1:

Table 2: Health Insurance Coverage Status

County	Population	Private Coverage[13]	Public Coverage[14]	Uninsured[15]
Anderson	57,001	47.5%	28.3%	25.4%
Bowie	93,964	56.2%	33.3%	20.1%
Camp	12,793	N/A	41.8%	23.2%
Cass	29,203	57.3%	40.9%	17.7%
Cherokee	48,473	52.5%	34.3%	23.2%
Delta	5,410	N/A	36.8%	20.1%
Fannin	32,999	56.4%	31.9%	22.0%
Franklin	10,841	N/A	27.5%	20.9%
Freestone	19,390	N/A	28.3%	21.2%
Gregg	119,637	59.7%	36.6%	20.6%
Harrison	64,795	60.6%	29.4%	21.3%
Henderson	78,921	52.3%	32.1%	22.0%
Hopkins	34,581	54.0%	32.5%	23.9%

[13] U.S. Census Bureau, 2008-2010 American Community Survey 3 Year Estimates

[14] Medicare Hospital and/or Supplemental Medical County Enrollment, Centers for Medicare and Medicaid Services (2010); Medicaid Enrollment by County, Point in Time, Health and Human Services Commission (February 2012); Texas Children's Health Insurance Program Enrollment by County and Month, Health and Human Services Commission (February 2012).

[15] U.S. Census Bureau, *Health Insurance Coverage Status* (2009).

Houston	22,363	48.6%	38.1%	23.2%
Hunt	82,831	58.3%	31.6%	22.5%
Lamar	48,965	56.8%	37.8%	20.0%
Marion	10,306	N/A	35.7%	21.1%
Morris	12,635	N/A	44.5%	18.3%
Panola	23,310	65.1%	30.1%	18.5%
Rains	11,287	N/A	31.6%	22.6%
Red River	12,765	N/A	41.4%	21.8%
Rusk	49,180	54.5%	29.0%	21.1%
Smith	204,665	61.8%	32.7%	20.8%
Titus	30,206	55.5%	35.8%	26.2%
Trinity	13,897	N/A	43.3%	20.7%
Upshur	38,057	59.1%	32.7%	20.6%
Van Zandt	52,005	55.5%	32.1%	23.9%
Wood	43,136	55.2%	39.3%	20.4%

Taken as a whole, approximately 54% of residents in Region 1 are uninsured or on some form of publicly supported insurance (Medicare, Medicaid, or the Children's Health Insurance Program). The highest private insurance coverage rates were found in Harrison, Smith, and Panola Counties.

Table 3: Urbanization, Age and Race/Ethnicity/Language[16]

County	Population	Rural Population	Population <18 Yrs	Population 65+ Yrs	African American	Hispanic	Not Proficient in English
Anderson	57,001	41.3%	20.2%	13.0%	22.5%	14.6%	4.1%
Bowie	93,964	32.9%	24.4%	13.7%	24.6%	6.1%	2.8%
Camp	12,793	60.5%	28.0%	15.4%	17.0%	22.9%	11.6%
Cass	29,203	81.3%	22.9%	19.4%	18.8%	2.8%	1.8%
Cherokee	48,473	60.8%	26.1%	14.5%	14.6%	19.5%	8.1%
Delta	5,410	100.0%	21.6%	18.6%	7.9%	5.4%	2.0%
Fannin	32,999	68.9%	22.6%	16.8%	7.6%	8.2%	3.6%
Franklin	10,841	93.9%	23.8%	18.1%	5.6%	14.2%	5.6%
Freestone	19,390	59.3%	23.4%	15.6%	17.8%	12.5%	3.7%
Gregg	119,637	19.8%	26.9%	13.7%	20.3%	14.1%	7.5%
Harrison	64,795	58.6%	25.4%	12.8%	22.4%	9.6%	4.7%
Henderson	78,921	54.4%	23.0%	18.7%	6.5%	10.3%	4.5%
Hopkins	34,581	59.1%	25.7%	14.8%	7.8%	14.6%	7.4%
Houston	22,363	70.9%	21.5%	18.7%	25.9%	10.5%	2.7%
Hunt	82,831	55.5%	25.0%	13.5%	8.8%	12.4%	4.6%
Lamar	48,965	46.1%	24.7%	16.2%	13.3%	5.9%	2.9%
Marion	10,306	100.0%	20.0%	21.2%	21.3%	3.7%	0.8%
Morris	12,635	80.0%	24.8%	19.0%	22.9%	6.4%	2.5%
Panola	23,310	74.5%	24.8%	15.8%	18.0%	7.1%	2.6%
Rains	11,287	100.0%	20.4%	20.5%	3.1%	9.0%	1.8%
Red River	12,765	74.6%	21.6%	19.5%	17.0%	5.9%	2.4%

[16] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org.

Rusk	49,180	67.0%	24.1%	14.7%	18.1%	12.6%	4.6%
Smith	204,665	38.6%	25.8%	14.6%	18.0%	16.3%	7.2%
Titus	30,206	52.2%	31.5%	11.7%	10.1%	39.1%	19.4%
Trinity	13,897	100.0%	21.8%	22.5%	11.2%	7.4%	4.2%
Upshur	38,057	80.3%	25.5%	13.8%	9.6%	5.6%	2.1%
Van Zandt	52,005	79.0%	23.5%	17.7%	3.6%	10.0%	3.6%
Wood	43,136	79.7%	20.6%	23.4%	6.0%	8.4%	3.5%
RHP 1	**1,263,616**	**53.9%**	**24.6%**	**15.5%**	**15.4%**	**12.2%**	**5.3%**
TEXAS	**24,782,302**	**17.5%**	**27.8%**	**10.2%**	**11.5%**	**36.9%**	**14.4%**

Table 3 shows data related to urbanization, age, and race, ethnicity, and language demographic data for the region and each county within the region. As shown in the table, over half of the region's residents live in a rural area, which contributes to challenges accessing primary care, specialty care, and mental health services.

Table 4: Educational Attainment[17]

County	High School Graduation	Some College
Anderson	92.9%	36.9%
Bowie	92.7%	51.9%
Camp	97.3%	38.2%
Cass	96.6%	51.4%
Cherokee	91.9%	34.9%
Delta	95.8%	46.3%
Fannin	94.0%	42.6%
Franklin	97.9%	46.7%
Freestone	94.8%	46.5%
Gregg	86.5%	55.4%
Harrison	90.2%	47.9%
Henderson	93.7%	46.9%
Hopkins	94.5%	49.0%
Houston	93.1%	38.7%
Hunt	88.1%	46.2%
Lamar	91.4%	51.8%
Marion	82.7%	42.4%
Morris	93.3%	57.4%
Panola	84.9%	49.7%
Rains	96.4%	40.8%
Red River	95.2%	39.0%
Rusk	94.0%	44.2%
Smith	87.8%	57.7%
Titus	97.8%	37.1%
Trinity	83.8%	32.3%
Upshur	94.2%	51.1%
Van Zandt	89.7%	43.8%
Wood	93.5%	41.9%

[17] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org

RHP 1	**91.1%**	**48.2%**
TEXAS	**84.3%**	**56.2%**

While the region has a higher high school graduation rate than the state average, it lags behind the state on college education. As shown in Table 4, only 48.2% of the regional population reported having "some college" compared to 56.2% of the state's population. The percentage achieving at least a bachelor's degree is even lower – 13.1% in region 1 compared to over 25% for the state.

Table 5: Income, Employment, and Poverty[18]

County	Median Household Income	Unemployment	Children in Poverty	Single-Parent Households
Anderson	$40,482	9.5%	27.2%	32.3%
Bowie	$42,272	8.3%	27.8%	39.3%
Camp	$37,704	8.8%	33.7%	41.1%
Cass	$34,556	11.0%	32.4%	42.5%
Cherokee	$34,910	9.1%	35.4%	32.1%
Delta	$36,193	9.1%	27.8%	30.1%
Fannin	$40,891	9.3%	24.1%	24.9%
Franklin	$40,579	7.7%	25.3%	29.7%
Freestone	$42,266	6.6%	23.7%	20.5%
Gregg	$41,623	7.2%	29.8%	36.9%
Harrison	$44,506	8.8%	25.6%	35.3%
Henderson	$37,137	8.6%	30.7%	31.7%
Hopkins	$40,446	6.8%	28.4%	26.0%
Houston	$33,198	9.8%	32.7%	39.5%
Hunt	$41,841	8.8%	28.0%	32.5%
Lamar	$38,852	9.0%	27.4%	31.2%
Marion	$32,173	10.3%	35.4%	43.6%
Morris	$34,451	13.0%	31.7%	46.1%
Panola	$48,621	7.3%	20.5%	31.2%
Rains	$40,966	9.2%	28.1%	35.3%
Red River	$32,128	11.0%	31.7%	35.2%
Rusk	$43,318	7.6%	23.6%	27.1%
Smith	$44,249	7.9%	21.7%	32.1%
Titus	$37,818	7.8%	29.5%	30.0%
Trinity	$34,045	8.8%	32.0%	36.9%
Upshur	$42,508	7.8%	25.5%	31.8%
Van Zandt	$41,476	7.6%	23.6%	25.5%
Wood	$40,149	8.6%	33.9%	25.9%
TEXAS	**$48,622**	**8.2%**	**25.7%**	**32.2%**

According to the World Health Organization, "people who are less well off have substantially shorter life expectancies and more illnesses than the rich" even in the most wealthy countries

[18] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org

in the world.[19] As shown in Table 5 above, median household income is less than the statewide average in every county in Region 1, with 11 of the 28 counties reporting median household incomes at least $10,000 less than the statewide average. Over 27% of children live in poverty and 32.7% of households are single-parent households in the region.

C. Healthcare Infrastructure

This subsection examines the existing healthcare environment in Region 1, including the number of healthcare professionals working in Northeast Texas and the hospital infrastructure in the region.

Research by the School of Rural Public Health at Texas A&M University reports that "access to timely and effective primary care is deemed critical to avoiding hospitalizations for ambulatory care sensitive conditions"[20] yet there is a significant provider shortage in Northeast Texas.

Table 6 below summarizes the health professionals by county in Region 1.

Table 6: Health Professionals by County

County	HPSA Designation[21]			Medically Underserved Area or Population[22]	Provider Ratios[23]		
	Primary Care	Dental	Mental Health		PCP	Dentist	Mental Health
Anderson	Yes	No	Yes	Yes	2268:1	3404:1	5155:1
Bowie	Yes	Yes	Yes	Yes	702:1	2010:1	4633:1
Camp	Yes	No	Yes	Yes	1056:1	4084:1	12673:0
Cass	Yes	No	Yes	Yes	1720:1	4310:1	29237:0
Cherokee	No	No	Yes	Yes	1786:1	4139:1	1786:1
Delta	Yes	Yes	Yes	Yes	2728:1	5199:1	5455:0
Fannin	Yes	Yes	Yes	Yes	4717:1	11214:1	16509:1
Franklin	Yes	No	Yes	Yes	1357:1	5399:1	10856:0
Freestone	Yes	No	Yes	Yes	3180:1	6387:1	19077:0
Gregg	Yes	Yes	Yes	Yes	829:1	1478:1	4707:1
Harrison	Yes	Yes	Yes	Yes	2199:1	4547:1	12755:1
Henderson	Yes	No	Yes	No	1432:1	4886:1	9845:1
Hopkins	No	No	No	Yes	1101:1	4291:1	17073:1
Houston	Yes	No	Yes	Yes	1609:1	2955:1	11266:1

[19] Wilkinson, Robert and Marmot, Michael, editors. *Social Determinants of Health: The Solid Facts.* 2nd Edition. The World Health Organization (2003).

[20] Gamm, Larry D., Hutchison Linna L., Dabney, Betty J. and Dorsey, Alicia M., eds. (2003). *Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volume 1.* College Station, Texas: The Texas A&M University Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.

[21] U.S. Department of Health and Human Services. Health Resources and Services Administration. HPSA by State & County.

[22] U.S. Department of Health and Human Services. Health Resources and Services Administration. MUA/P by State & County.

[23] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org

Hunt	Yes	Yes	Yes	Yes	2165:1	3667:1	4839:1
Lamar	No	No	No	Yes	1749:1	1899:1	9792:1
Marion	Yes	No	Yes	Yes	N/A	10951:1	N/A
Morris	Yes	No	No	Yes	2564:1	2208:1	12821:1
Panola	Yes	Yes	Yes	Yes	2108:1	5837:1	11593:1
Rains	Yes	No	Yes	No	3756:1	10994:1	5635:1
Red River	Yes	No	Yes	Yes	3230:1	6536:1	12918:0
Rusk	Yes	Yes	Yes	Yes	1748:1	4273:1	24475:1
Smith	Yes	Yes	Yes	Yes	617:1	1999:1	2756:1
Titus	Yes	Yes	No	No	1411:1	2325:1	14819:1
Trinity	Yes	Yes	Yes	Yes	3484:1	7212:1	13934:0
Upshur	Yes	No	Yes	Yes	2228:1	7655:1	18941:1
Van Zandt	Yes	No	Yes	Yes	4739:1	3476:1	17377:1
Wood	Yes	Yes	Yes	Yes	1710:1	3764:1	21379:1
RHP 1	**89.3%**	**42.9%**	**85.7%**	**89.3%**			

As shown in the table above, access to care is a pressing need in Northeast Texas. Nearly 90% of counties in Region 1 are designated as health professional shortage areas for primary care, and slightly fewer (85.7%) are designated as shortage areas for mental health professionals. As a whole, 89.3% of counties (all but three) are listed as medically underserved areas or populations. The ratio of patients to providers (both for primary care and mental health) is significantly higher than statewide averages or national benchmarks. For example, in some communities, the ration of patients to primary care providers is nearly 5,000 to one, compared to statewide average of 1,050 to one and a national benchmark of 631 to one. The problem is even more serious in mental and behavioral health, where the ratio approaches 30,000 to one in one community, compared to a statewide average of 3,600 to one. Providers tend to be clustered in more populated areas (Smith, Gregg, and Bowie Counties), but the majority of residents in Northeast Texas live in rural areas. Even in the larger areas such as Smith, Gregg, and Bowie Counties, there is no city with a population greater than 100,000.

Like health professionals, hospital infrastructure tends to be clustered in larger communities of Region 1. Table 7 below shows data from the 2010 Department of State Health Services/American Hospital Association/Texas Hospital Association Annual Survey of Hospitals and Hospital Tracking Database.

Table 7: Hospital Infrastructure[24]

County	Acute Care Hospitals	Acute Care Staffed Beds	Behavioral Health Inpatient Beds[25]	Acute Care Inpatient Days			Uncompensated Care (UC)	
				Total Days	Medicare Days	Medicaid Days	Total Uncompensated Care Charges	UC as % of Gross Patient Revenue
Anderson	2	118	37	22,505	12,255	4,206	$23,174,491	10.6%
Bowie	5	628	15	138,396	86,458	15,655	$207,191,276	15.6%

[24] DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database (2010).
[25] Provider survey conducted by Palestine Regional Medical Center (September 2012).

Camp	1	25	0	4,813	3,539	462	$14,886,260	13.0%
Cass	2	62	0	10,213	7,007	768	$9,161,202	14.4%
Cherokee	2	58	172	12,794	7,589	2,058	$45,378,453	15.5%
Delta	0	0	0	0	0	0	$0	0.0%
Fannin	1	25	0	3,180	2,234	179	$2,486,668	4.8%
Franklin	1	30	0	2,120	1,576	118	$2,673,723	11.5%
Freestone	1	20	0	2,682	2,143	118	$8,754,013	16.4%
Gregg	4	612	122	132,842	74,355	22,187	$199,549,150	10.7%
Harrison	1	122	41	13,494	7,055	3,385	$41,575,108	17.9%
Henderson	1	117	0	27,382	16,247	3,793	$69,969,387	16.2%
Hopkins	1	54	0	12,430	6,843	2,402	$11,695,884	10.8%
Houston	1	49	0	8,024	4,241	1,383	$10,461,568	11.6%
Hunt	2	192	22	30,019	13,315	3,493	$30,442,626	11.6%
Lamar	2	251	37	41,917	24,268	5,185	$28,741,371	7.2%
Marion	0	0	0	0	0	0	$0	0.0%
Morris	0	0	0	0	0	0	$0	0.0%
Panola	1	37	0	3,761	1,771	961	$14,232,642	15.5%
Rains	0	0	0	0	0	0	$0	0.0%
Red River	1	36	0	5,246	3,851	294	$8,798,980	14.2%
Rusk	1	47	0	6,616	4,012	1,246	$13,119,446	15.9%
Smith	8	1,175	75	308,857	186,089	35,494	$467,898,836	9.9%
Titus	1	93	15	21,718	13,716	2,146	$17,256,646	10.2%
Trinity	1	22	0	2,661	1,789	459	$5,453,891	14.5%
Upshur	1	37	0	1,997	1,522	113	$9,495,927	18.4%
Van Zandt	1	24	0	2,227	1,305	296	$235,456	1.0%
Wood	2	25	0	4,141	2,757	238	$9,658,066	14.1%
RHP 1	**44**	**3,859**	**536**	**820,035**	**485,937**	**106,639**	**$1,252,291,070**	**11.5%**

Many of the region's acute care hospitals are small hospitals located in rural communities. Because these same communities lack sufficient primary care physicians, residents must drive great distances to access primary health care services and acute health care services.

As mentioned previously, the demands on the region's mental and behavioral health infrastructure is strained. At the community level, community mental health centers need additional providers and technology to meet the growing demand for services. Rusk State Hospital, the single psychiatric hospital located in the region, was on diversion for 213 of 365 days in state fiscal year 2012.[26]

D. Health Challenges

Many of the health challenges in Northeast Texas are related to chronic diseases and ambulatory care sensitive conditions. Below is a summary of health outcomes and challenges in Northeast Texas:

[26] Texas Department of State Health Services (2012). *Diversion Reports FY 2012 Summary.*

- **High Blood Pressure**: DSHS estimates that 43.1% of the African American population in East Texas has high blood pressure compared to 33.9% of the African American population in Texas. High blood pressure among Caucasians in East Texas is slightly higher (32.4%) compared to the state (28.2%)[27].

- **Cholesterol Screenings:** DSHS estimates that the African American, Hispanic, and Caucasian population in East Texas have lower cholesterol screening rates than the state as a whole. According to DSHS, 83.5% of the Hispanic population in East Texas has not had their cholesterol checked within the last five years (compared to 57.5% of the statewide Hispanic population). For African Americans in East Texas, 45.3% have not had a cholesterol screening in the last five years (compared with 26.1% of the statewide African American population). 28.3% of Caucasians in East Texas had not had a cholesterol screening in five years (compared with 22.4% of the statewide Caucasian population).[28]

- **Mental/Behavioral Health:** An estimated 85,000 individuals in East Texas have a serious mental illness, and approximately 113,000 individuals need treatment for alcohol or drug abuse, but do not receive it. East Texas has a suicide rate 65% higher than the rate for Texas (18.2 per 100,000 in East Texas compared to 11.0 per 100,000 in Texas).[29]

- **Obesity:** The percentage of the adult population that is obese ranges from 25.5% to 34.1% in Region 1 counties. Statewide, the prevalence of adult obesity is estimated at 30.4%. Obesity is a costly condition. According to the Centers for Disease Control and Prevention, nationwide medical costs associated with obesity were estimated at $147 billion in 2008. The medical costs for individuals who are obese were $1,429 higher than those of normal weight.[30]

- **Diabetes:** The 2009 Texas Behavioral Risk Factor Surveillance System estimated that 9.3% of adults in Texas have been diagnosed with diabetes.[31] In Region 1, estimates of the adult diabetic population range between a low of 9.2% to a high of 13.0%.[32]

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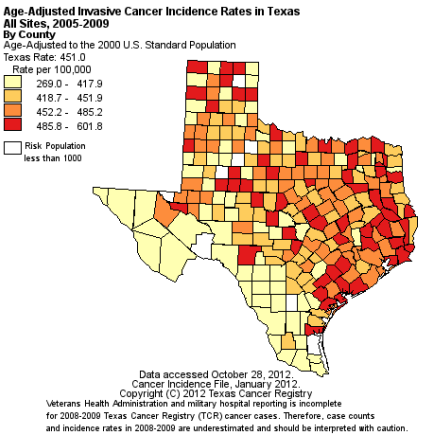
[27] Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.
[28] Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.
[29] Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.
[30] Centers for Disease Control and Prevention. (2012, October). *Overweight and Obesity*. Retrieved October 2012, from Centers for Disease Control and Prevention: http://www.cdc.gov/obesity/data/adult.html
[31] Texas Department of State Health Services. *Texas Behavioral Risk Factor Surveillance System* (2009).
[32] University of Wisconsin Population Health Institute. (2012, July). *County Health Rankings 2012*. Retrieved July 2012, from County Health Rankings: www.countyhealthrankings.org

- **Cardiovascular Disease:** East Texas has a high proportion of counties where the age-adjusted mortality rates for congestive heart failure and ischemic heart disease were higher than the state rate.[33]

- **Cancer Incidence & Mortality:** The map (at right) shows that Northeast Texas has higher age-adjusted invasive cancer incidence rates (all sites) than the statewide average.[34] The mortality rates for men for all sites cancer is 246.3 per 100,000 in the Northeast Texas region compared to a statewide rate of 212.4, with lung, colorectal, and pancreatic cancer showing the greatest difference between regional and statewide rates. For women, the mortality rate is 154.2 per 100,000 in the region compared to a statewide rate of 142.8, with lung and ovarian cancer showing the greatest difference in regional and statewide mortality rates.[35]



E. Healthcare Cost, Efficiency, and Effectiveness

An important factor in reforms to the healthcare delivery system is cost. Three major functions of cost – potentially preventable hospitalizations, emergency department utilization, and national health expenditures – are examined here.

Potentially Preventable Hospitalizations

The Texas Department of State Health Services collects data on potentially preventable hospitalizations. Preventable hospitalization conditions were selected by the Agency for Healthcare Research and Quality, the lead federal agency responsible for research on health care quality, costs, outcomes, and patient safety. Table 7 below shows data from Region 1 on hospitalizations for ten conditions that are potentially preventable, meaning that "if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred."[36]

[33] Texas Department of State Health Services. *Texas Chronic Disease Report* (2010).
[34] Texas Department of State Health Services. *Age Adjusted Invasive Cancer Incidence Rates in Texas, All Sites, 2005-2009.*
[35] Texas Department of State Health Services. *2012 Texas Selected Cancer Facts for Health Service Region 4.*
[36] Texas Department of State Health Services. (2012, October). *Potentially Preventable Hospitalizations*. Retrieved October 2012, from Texas Department of State Health Services: http://www.dshs.state.tx.us/ph/

Table 8: Potentially Preventable Hospitalizations and Cost[37]

	Number of Hospitalizations (2005-2010)	Total Hospital Charges (2005-2010)	Average Charge Per Hospitalization
Angina (without procedures)	1,971	$31,482,485	$15,972.85
Asthma	5,989	$124,053,064	$20,713.49
Bacterial Pneumonia	27,902	$723,511,223	$25,930.44
Chronic Obstructive Pulmonary Disease	17,025	$395,588,007	$23,235.71
Congestive Heart Failure	30,968	$796,053,057	$25,705.67
Dehydration	8,831	$141,924,306	$16,071.15
Diabetes Long-term Complications	7,326	$256,096,467	$34,957.20
Diabetes Short-term Complications	3,288	$69,719,456	$21,204.21
Hypertension (High Blood Pressure)	4,276	$81,579,895	$19,078.55
Urinary Tract Infection	14,293	$268,871,765	$18,811.43
RHP 1	**121,869**	**$2,888,879,725**	**$23,704.80**

As noted in the table above, from 2005-2010, there were approximately 122,000 potentially preventable hospitalizations reported in Region 1 with over $2.8 billion in hospital charges related to those admissions.

Emergency Department Utilization

Research by the Center for Studying Health System Change (HSC) shows that "emergency department use has increased substantially over the past 15 years" and that emergency rooms are a "major source of primary health care in the community, treating a broad range of health problems that include many visits for minor ailments and other 'nonurgent' conditions."[38]

In addition, HSC notes that "two thirds of all emergency department visits occur outside normal business hours" and that "increasing the number of primary care providers in the community who are available after normal business hours is essential" to reducing primary care-related emergency department utilization.[39]

The data presented in previous sections of this community needs assessment shows that Region 1 has insufficient primary care access. Further, research by a number of sources, including the Center for Studying Health System Change, shows a connection between primary health care and emergency department use. Performing providers in Region 1 echo this finding

[37] Texas Department of State Health Services. (2012, October). *Preventable Hospitalizations - County Profiles*. Retrieved October 2012, from Texas Department of State Health Services: http://www.dshs.state.tx.us/ph/county.shtm

[38] Cunningham, Peter. *Nonurgent Use of Hospital Emergency Departments.* Testimony before the United States Senate Committee on Health, Education, Labor, and Pensions, Subcommittee on Primary Health and Aging (May 11, 2011).

[39] Cunningham, Peter. *Nonurgent Use of Hospital Emergency Departments.* Testimony before the United States Senate Committee on Health, Education, Labor, and Pensions, Subcommittee on Primary Health and Aging (May 11, 2011).

and have included data specific to their emergency departments in the narratives of delivery system reform projects.

Trends in National Health Expenditures

According to data from the Centers for Medicare and Medicaid Services, national health expenditures (NHE) continue to grow, straining resources at the state and federal levels.

Table 9: National Health Expenditures (2009)[40]

	Historic (2009)	
	Growth Rate	**Relative Share**
Total National Health Expenditure	4.0%	17.6% of GDP
Medicare Spending	7.9%	20% of NHE
Medicaid Spending	9.0%	15% of NHE
Private Health Insurance Spending	1.3%	32% of NHE
Out of Pocket Spending	0.4%	12%
Hospital Expenditures	5.1%	N/A
Physician and Clinical Services	4.0%	N/A

F. Related Federal Initiatives

A table showing related federal initiatives is available in the addendum.

Within project narratives, performing providers have detailed the nature of the relationship between the proposed DSRIP project and any related federal initiative, including a certification by the performing provider that the DSRIP project is not duplicative of any related federal initiative.

G. Relevant Delivery System Reform Initiatives

Addressing these community needs is a priority to the region. As a result, the delivery system reform projects developed by the regional health partnership show an integration of individual community needs, with many projects addressing multiple community needs. The table below summarizes the number of proposed Pass 1 projects that address the community needs outlined above.

[40] Centers for Medicare and Medicaid Services. (2012, October). *NHE Fact Sheet*. Retrieved October 2012, from Centers for Medicare & Medicaid Services: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html

Table 10: Proposed Pass 1 Projects by Community Need[41]

Community Need Identifier	Number of Proposed Pass 1 Projects
CN.1 – Insufficient access to primary and specialty care services.	32
CN.2 – Insufficient access to mental and behavioral health services.	14
CN.3 – High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.	10
CN.4 – High costs due to potentially preventable hospitalizations.	9
CN.5 – Inappropriate emergency room utilization.	18
CN.6 – Efficiency in and effectiveness of health care delivery.	9

As shown in Table 10, the clear focus of the region is on expanding access to care – both physical and mental/behavioral health care services. Because of the interrelatedness of access to care and other community needs, such as emergency room use, preventable hospitalizations, and cost, the regional emphasis on expanding access will have a significant impact on transformation in other community need domains.

H. Projected Major Changes FFY 2012 – FFY 2016

Texas is a growing state, and Northeast Texas is likewise expected to grow. As outlined in the ETCHNA report, the region's population is projected to increase 24% by 2040, with significant growth (260%) in the Hispanic population.[42] Growth in the population will naturally increase demand on the healthcare infrastructure in Northeast Texas, especially as the region's population is expected to remain older than the state average.

The Centers for Medicare and Medicaid Services anticipates that Medicare enrollment growth will be a "stronger influence on future spending growth than the changing age-mix of the Medicare population" a statistic that is an important regional consideration given the median age of Northeast Texas. More generally, in the short term, national health expenditures are projected to rise 7.4% by 2014. Medicaid spending growth is projected at 18.0%, while private health insurance growth of 7.9% is expected. A slight decline of 1.5% is expected for out of pocket health spending. Over the period of 2015-2021, health spending is projected to grow at an average rate of 6.2% annually.[43] Given this trend, efficiency in and effectiveness of our healthcare delivery system is an important community need in Northeast Texas.

The demands on the healthcare environment in Northeast Texas will remain strong for the foreseeable future. Addressing these demands in an efficient and effective way remains a core task for the regional healthcare partnership.

[41] At the time of submission of this community needs assessment, the number, type, and scope of projects have not been finalized. The data presented in Table 10 is the best available information as of October 31, 2012.
[42] Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.
[43] Centers for Medicare and Medicaid Services. *National Health Expenditure Projections 2011-2021.* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

Section IV. Stakeholder Engagement

The University of Texas Health Science Center at Tyler's (UTHSCT) stakeholder engagement activities predate the state appointing the institution as Anchor for RHP 1. Shortly after the demonstration waiver was approved by the Centers for Medicare and Medicaid Services (CMS), Dr. Kirk A. Calhoun, UTHSCT President, was named to the state's Executive Waiver Committee and asked to help disseminate information to stakeholders in Northeast Texas. Key staff at UTHSCT conducted a stakeholder analysis and developed a database that included contact information for individuals and organizations that would likely be stakeholders in the demonstration waiver.

Having identified the likely stakeholders, Dr. Calhoun and UTHSCT staff travelled the region, meeting one-on-one with stakeholders at their hospitals and offices, beginning with historic intergovernmental transfer (IGT) entities, public hospitals, county officials, and large private hospital systems. The purpose of these early meetings was to disseminate information from the Health and Human Services Commission and educate stakeholders about the demonstration waivers. Meeting face-to-face at a stakeholder's office was also critical to understanding the unique needs of each community in the region, and it fostered trusting relationships that have been especially helpful as the regional healthcare partnership was developed.

In March 2012, UTHSCT hosted a public meeting with nearly 100 stakeholders, including county officials, hospital providers, local mental health authorities, IGT entities, county medical societies, Federally Qualified Health Centers (FQHCs), and many others from across Northeast Texas and officials from the Health and Human Services Commission (HHSC). The purpose of the meeting was for stakeholders to be able to interact directly with HHSC staff and seek clarification on different aspects of the demonstration waiver.

In May 2012, HHSC named the University of Texas Health Science Center at Tyler as the Anchor for RHP 1. Immediately, UTHSCT recognized that it functioned in three different capacities: as an IGT contributor, as a performing provider, and as the Anchor. It was clear that because of the important and unique role an Anchor fulfills in the demonstration waiver, a clear separation of responsibilities was necessary. So UTHSCT leadership separated each function and created a firewall around the Anchor staff, so that, as Anchor, UTHSCT could function as an independent advisor to regional stakeholders. As Anchor, UTHSCT's focus has been on establishing trust with regional partners, developing productive relationships with participants, and encouraging regional collaboration.

In all, UTHSCT conducted over three dozen public outreach activities in over 15 different communities in Region 1.

A. RHP Participants Engagement

As Anchor, UTHSCT's overall approach to participant engagement was to be responsive and accessible and to tailor outreach efforts to the unique challenges in rural Texas. Below is a high-level description of participant engagement activities in RHP 1.

Public Meetings

Three public meetings and two public hearings were held in Region 1 between March 2012 and December 2012. All public meetings were open to the public, recorded, and the video and presentations from the meetings were archived on the RHP's website. Public posting of meeting videos and presentations was useful both to providers that were unable to attend the meeting due to scheduling conflicts and for the general public to review meeting information. The table below lists the public meetings and public hearings held by the RHP. All videos and presentations can be found online at www.uthct.edu/waiver.

Date	Meeting Type	Location
March 22, 2012	Regional Stakeholder Meeting with HHSC	Tyler
June 12, 2012	Public Meeting	Tyler
October 26, 2012	Public Meeting	Longview
November 9, 2012	Public Hearing (Pass 1)	Mt. Pleasant
December 21, 2012	Public Hearing (Full Plan)	Tyler

Behavioral Health Work Sessions

Early in the demonstration waiver process, regional stakeholders identified behavioral health services as a critical community need in RHP 1. As Anchor, UTHSCT held two work sessions with hospitals and behavioral health providers to work together to develop a cohesive behavioral health services strategy for RHP 1. The table below lists the two work sessions held by the RHP.

Date	Meeting Type	Location	Participants
June 6, 2012	Behavioral Health Collaborative Work Session	Lindale	Hospitals, Local Mental Health Authorities.
July 19, 2012	Behavioral Health Collaborative Work Session	Longview	Hospitals, Local Mental Health Authorities, and FQHCs in Northeastern Area of RHP.

Webinars

Regular, consistent communication is key to coordinating provider activities under the demonstration waiver; yet, because RHP 1 is a rural region approximately 250 miles from point-to-point, it was important to utilize technology to facilitate waiver communications. UTHSCT is home to NETnet, a collaborative broadband effort to bring education, especially healthcare education, to 50 rural counties in Northeast Texas. Utilizing this infrastructure, the RHP held webinars to provide information, answer questions, gather stakeholder feedback, and assist providers with completion of requirements under the demonstration waiver. Webinars began

once final protocols were approved and were held on Fridays immediately following the weekly Anchor call with HHSC. As with the public meetings, the webinars were recorded. The table below shows the dates of each webinar.

Date	Type of Meeting
April 18, 2012	RHP 1 Outreach Webinar with HHSC
September 27, 2012	RHP 1 Technical Assistance Webinar with HHSC
October 4, 2012	RHP Webinar
October 12, 2012	RHP Webinar
November 2, 2012	RHP Webinar
November 30, 2012	RHP Webinar
December 7, 2012	RHP Webinar
December 14, 2012	RHP Webinar
January 25, 2013	RHP Webinar
February 15, 2013	RHP Webinar

Technical Assistance

Prior to initial Pass 1 submission in November 2012, the RHP conducted a stakeholder survey to determine what type of assistance stakeholders needed to help them successfully develop projects for the regional health plan. In addition to providing region-wide technical assistance to providers, the Anchor scheduled one-on-one phone conferences with individual providers to provide assistance specific to that provider's projects.

External Quality Review

Prior to inclusion in the regional health plan, Pass 1 projects were reviewed by an external quality expert who provided feedback and suggestions for improvement to each provider. Providers revised their projects based on this feedback and utilized the feedback to strengthen Pass 2 and Pass 3 projects.

Other Outreach

In addition to the outreach activities listed above, the Anchor regularly emailed stakeholders with updated information from HHSC, conducted stakeholder surveys, and made countless one-on-one phone calls with individual providers.

Ongoing Engagement

The RHP plans to continue regular communication and participant engagement through webinars, quarterly/semi-annual meetings, and other meetings in partnership with planned learning collaboratives.

B. Public Engagement

All activities of the RHP were open the public, including all meetings and webinars. All interested parties, whether performing providers, IGT contributors, or other stakeholders, including the public, were part of the stakeholder database used to email information to regional stakeholders.

Public Meetings

As mentioned previously, all public meetings were recorded and archived on the RHP website, and all content on the RHP webiste was open to the public. The RHP held numerous meetings focused on non-participant stakeholders and the public. The sections below describe some of those outreach activities.

County Official Engagement

County government is an important public stakeholder in the demonstration waiver. In many cases, a county provides IGT match for waiver activities, and in all cases, county officials are key leaders in the community and have a clear understanding of the challenges in their communities. Because of this important role, several meeting were held with individual county officials and groups of county officials in various communities of the region. The table below summarizes county official engagement efforts in RHP 1.

Date	Meeting Type	Location	Participants
February 21, 2012	County Judge Meeting	Mt. Pleasant	Titus County Judge
February 21, 2012	County Judge Meeting	Mt. Vernon	Franklin County Judge
February 21, 2012	County Judge Meeting	New Boston	Bowie County Judge
February 24, 2012	County Judge Meeting	Longview	Gregg County Judge
March 14, 2012	County Judge Meeting	Pittsburg	Camp County Judge
March 14, 2012	County Judge Meeting	Sulphur Springs	Hopkins County Judge
March 15, 2012	ARK-TEX Council of Governments	Daingerfield	County Officials Covering a 9 County Region
March 21, 2012	East Texas Council of Governments	Kilgore	County Officials Covering a 14 County Region
April 9, 2012	Commissioners' Court Meeting	Paris	Lamar County Commissioner's Court
July 17, 2012	County Official Meeting	Mt. Pleasant	County Officials Covering a 9 County Region
July 17, 2012	County Official Meeting	Longview	County Officials Covering a 9 County Region
July 18, 2012	County Judge Meeting	Palestine	Anderson County Judge
December 6, 2012	County Official Meeting	Mt. Pleasant	County Officials Covering a 22 County Region

Other Healthcare Stakeholder Engagement

The terms of the demonstration waiver outlined which healthcare providers are eligible as performing providers; however, other healthcare stakeholders, including Federally Qualified Health Centers (FQHCs) and county medical societies were included in all outreach activities of the regional healthcare partnership. The table below summarizes some of the outreach efforts of the region to other healthcare stakeholders.

Date	Meeting Type	Location	Participants
February 15, 2012	Private Charitable Clinic	Tyler	Bethesda Health Clinic
May 2, 2012	Public Health Officers	Tyler	Local Public Health Departments and Public Health Officers in Northeast Texas
May 10, 2012	FQHC Meeting	Longview	WellnessPointe FQHC
May 14, 2012	Substance Abuse Meeting	Longview	East Texas Council on Alcohol and Drug Abuse
June 29, 2012	FQHC Meeting	Phone Conference	Mt. Enterprise Community Health Clinic (FQHC)
July 9, 2012	County Medical Society	Tyler	Smith County Medical Society
August 15, 2012	FQHC Meeting	Tyler	DSHS Primary Care Contractor Meeting Covering Multiple FQHCs Across Region
December 12, 2012	Emergency Services	Tyler	EMS/Trauma Providers Covering 19 Counties in Northeast Texas
March 1, 2013	Mental Health Continuing Education Conference	Kilgore	Mental health providers from across Northeast Texas

Public Posting of Regional Health Plan & Public Comment Process

There were two public comment periods for the RHP 1 regional health plan. The first public comment period (November 5-9, 2012) covered all Pass 1 projects and relevant sections of the regional health plan. The second public comment period (December 17-21) covered the full regional health plan, and included all projects and all sections of the plan.

In addition to posting the regional health plan online, the plan was distributed by the Regional Director for Public Health Region 4/5N for the Department of State Health Services, and a public hearing was conducted during each public comment period. Notices were placed in major newspapers throughout the region informing the general public of the website for the plan, the process for public comment, and the date, time, and location of the public hearings. Interested parties could provide comment in two ways: (1) completing a public comment form and submitting it via email to the Anchor or (2) provide comments (written or verbal) at a public hearing. During the public comment period, the Anchor provided a daily update to performing providers of all public comment received, so that they could consider public comment in revisions to their plans. In addition, the Anchor responded in writing to each individual providing public comment, and posted a summary of public comments and responses online. A summary of all public comment received and responses is attached in the addendum.

Ongoing Engagement

Consistent with the region's practice of public engagement, all future meetings and activities of the RHP will remain open to the public. The RHP plans to continue regular communication and participant engagement through webinars, quarterly/semi-annual meetings, and other meetings in partnership with planned learning collaboratives.

Section V. DSRIP Projects

A. RHP Plan Development

Regional Approach to Addressing RHP Plan Goals

The overarching goal and vision of the Northeast Texas Regional Healthcare Partnership (RHP 1) is to move toward a realization of the triple aim:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care.

In addition, the region has a clear focus on addressing gaps in access to primary and specialty care and in improving behavioral health services in the region. The most pressing needs in RHP 1, as evidenced by the community needs assessment, are:

- CN.1: Insufficient access to primary and specialty care services
- CN.2: Insufficient access to mental and behavioral health services
- CN.3: High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer
- CN.4: High costs due to potentially preventable hospitalizations
- CN.5: Inappropriate emergency department utilization
- CN.6: Efficiency in and effectiveness of health care delivery.

Addressing these critical needs is a priority for the region, and stakeholders are committed to collaborative partnerships that achieve the RHP goals and vision. In many cases, performing providers have collaborated with one another and other healthcare providers in the region to accomplish regional transformation. At various stages of the plan development process, stakeholders participated in work sessions with other providers to discuss regional needs and collaborate on joint projects. The delivery system reform incentive payment (DSRIP) plans that follow are the result of a joint effort of public and private healthcare providers to improve the delivery system in the Northeast Texas community.

Implementation of Pass 1 and Pass 2, and Methodology for Pass 3

Implementation of Pass 1 and Pass 2 complied with the requirements of the Program Funding & Mechanics Protocol (PFM), and allocations were distributed to performing providers based on the formulas and methodologies developed by the Health and Human Services Commission. As a Tier 3 region, performing providers in RHP 1 were authorized by paragraph 25(c)iv to combine allocations to implement collaborative projects. Many projects within this regional health plan are the result of collaborative relationships, which strengthens the regional health plan, leads to greater transformation of the healthcare delivery system, and supports a more cohesive regional health plan.

To determine a methodology for Pass 3 allocations, the Anchor distributed a stakeholder survey to determine which providers had remaining projects for consideration and to assess the capacity of intergovernmental transfer (IGT) entities to fund additional projects. Using the data gathered in the survey, the Anchor calculated the percentage of IGT each IGT entity contributed to themselves and others for DSRIP projects and distributed the remaining Pass 3 allocations based on that percentage. The methodology was approved by IGT contributors, who funded projects based on the region's outstanding community needs.

The process for determining Pass 3B allocations is discussed later in this Section.

Process for Evaluating and Selecting Projects

In order to guide the region in selecting only the most transformative projects, the Anchor developed a project scoring template for regional stakeholders to use in scoring projects considered by the regional healthcare partnership. Modified from a *National Institutes of Health* grant scoring tool, the scoring template assessed the strength of a project across five domains, shown in the table below:

Domain	Weight
Alignment with Community Needs	30%
Transformational Impact	25%
Integration with Other Projects/Partners	20%
Likelihood of Success	12.5%
Sustainability	12.5%
Total	**100%**

Projects were scored on a scale of 1-9, using the guidelines in the table below:

Impact	Score	Descriptor	Additional Guidance on Strengths/Weaknesses
High	9	Exceptional	Exceptionally strong with essentially no weaknesses
	8	Outstanding	Extremely strong with negligible weaknesses.
	7	Excellent	Very strong with only minor weaknesses.
Medium	6	Very Good	Strong but with numerous minor weaknesses.
	5	Good	Strong but with at least one moderate weakness.
	4	Satisfactory	Some strengths but also some moderate weaknesses.
Low	3	Fair	Some strengths but with at least one major weakness.
	2	Marginal	A few strengths and a few major weaknesses.
	1	Poor	Very few strengths and numerous major weaknesses.

For the purposes of this scoring template, the region used the following definitions from the *Guidelines for Reviewers Including Scoring Descriptors* from the Office of Extramural Research at the *National Institutes of Health*:

- **Minor Weakness:** Easily addressable weakness that does not substantially lessen impact.
- **Moderate Weakness:** Lessens impact
- **Major Weakness:** Severely limits impact.

Individual performing providers also rank ordered their projects based on that project's priority for that provider. A sample project scoring template is included in the addendum to this section.

Taken as a whole, the region considered 184 Category 1 and Category 2 projects for inclusion in the regional health plan. The table below shows that fewer than half of the projects considered by the regional healthcare partnership were included in the regional health plan:

Project Acceptance Summary	
Projects Considered by RHP	184
Projects Accepted by RHP	90
Pass 1 Projects	73
Pass 2 Projects	11
Pass 3 Projects	6
Acceptance Rate	48.9%

The most common reason a project was not selected was a low score on the project scoring template. The table below shows the three most common reasons a project was not chosen for inclusion in the regional health plan:

Reason Excluded from Regional Health Plan	Percentage of Projects
Low Score on Project Scoring Template	42.6%
Insufficient IGT or Allocation	25.5%
Project Goals Addressed By Other Selected Projects	13.9%

A complete list of the 94 projects considered but not included in the regional health plan is attached in the addendum.

Implementation of Pass 3B

The Program Funding & Mechanics Protocol allows certain providers to share allocation in order to implement a collaborative, transformative project. Several providers in Region 1 submitted projects in Pass 1 and Pass 2 that benefitted from collaborative relationships and shared allocation; however, in response to feedback from CMS, these partners withdrew their projects and deferred them to a new pass, known as Pass 3B.

Based on guidance from HHSC, the only projects eligible for consideration in Pass 3B were either (1) collaborative projects that were withdrawn or (2) projects that are on the region's list of projects considered but not included in the regional health plan. In all, providers withdrew

18 collaborative projects and two new projects were submitted from the region's list of projects considered but not included in the regional health plan.

Because the value of projects submitted for consideration in Pass 3B exceeded the amount of allocation available to the region, a transparent and fair process was necessary to determine which projects would receive allocation and be included in the regional health plan. Two external project reviewers with no financial or other conflicts of interest with any provider in Northeast Texas were asked to review all projects submitted in Pass 3B and score them using the same scoring tool used by the region in previous passes. The reviewers were masters-degreed registered nurses who are retired from the Texas Department of State Health Services as directors of public health nursing with a combined 57 years of experience in public health in Northeast Texas. Both have experience reviewing and scoring grants and RFPs for state and federally funded programs. Using the scores submitted by the reviewers, and considering the priorities to the region, available funding, and the population health focus of the Waiver, the Anchor included 17 Pass 3B projects in the regional health plan. The table below provides details on the Pass 3B projects that were not included in the regional health plan:

Project Type (New or Collaborative)	Provider
Collaborative	UT Health Science Center Tyler (UPA)
Collaborative	Texas Palliative Care *(withdrawn at provider's request)*
New	Hunt Regional Medical Center

Minimum Requirements for Regional Health Plan

The Program Funding & Mechanics Protocol outlines minimum requirements for a regional health plan. The Northeast Texas RHP (RHP 1) is classified as a Tier 3 region based on the following definition in paragraph 11(b)iii of the PFM: "an RHP that contains at least 3 percent and less than 7 percent share of the statewide population under 200 percent FPL as defined by the U.S. Census Bureau: 2006-2010 American Community Survey for Texas (ACS)."

The table below summarizes the specific requirements of a Tier 3 region, including minimum projects, major safety net participation, and broad hospital participation targets:

RHP Plan Element	PFM Requirement	RHP 1
Minimum Category 1 & 2 Projects	8 (at least 4 Category 2)	90 (47 Category 2)
Major Safety Net Hospital Participation	2	2
Broad Hospital Participation	15% nonprofit/private hospital participation	53%

Performing Providers Exempt from Category IV Reporting

Certain hospitals are exempted from required Category IV reporting. Hospitals that meet the criteria below are exempt from required Category IV reporting:

"A hospital is not a state-owned hospital or a hospital that is managed or directly or indirectly owned by an individual, association, partnership, corporation, or other legal entity that owns or managed one or more other hospitals and:

(1) Is located in a county that has a population estimated by the United States Bureau of the Census to be not more than 35,000 as of July 1 of the most recent year for which county population estimates have been published; or

(2) Is located in a county that has a population of more than 35,000, but that does not have more than 100 licensed hospital beds and is not located in an area that is delineated as an urbanized area by the United States Bureau of the Census."

The following performing providers are exempt from Category IV reporting according to the criteria in paragraph 11(f) in the Program Funding & Mechanics Protocol:

Performing Provider	TPI Number
Hopkins County Memorial Hospital	131037704

B. Project Valuation

Regional Approach

While individual performing providers were responsible for valuing their projects individually, stakeholders, as a whole, considered common factors in determining valuation, including size, project scope, populations served, benefit to the community, cost savings, and alignment with community needs. Providers also considered whether their project had a high, medium, or low impact score on the project scoring template. At the individual project level, project narratives contain a justification for the valuation used, including the specific factors used to determine valuation for each individual project.

Valuation for Similar Projects

Because the region's clear focus is on improving access to primary care and behavioral health services, it is natural that similar projects were submitted by different performing providers in different areas of the region. An important consideration in the valuation of similar projects was the size and impact of an individual provider, which can vary widely in RHP 1. For example, hospital providers range from very small hospitals in rural areas to a larger Level 1 trauma center in a more metropolitan area of the region. In each project narrative, providers describe their approach to valuation of that individual project and include verifications that projects are not duplicative with similar projects in the region.

C. Category 1: Infrastructure Development

Infrastructure development projects lay the foundation for delivery system transformation through investments in technology, tools, and human resources. Performing Providers participating in Category 1 projects may include hospitals, community mental health centers (CMHCs), local health departments, physician practices affiliated with academic science health centers, and physician practices not affiliated with academic health science centers, as defined in Section II of Attachment J (Program Funding and Mechanics Protocol).

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 017624002.1.1 (Pass 1)
Performing Provider Name/TPI: ETMC Quitman 017624002

Project Abstract

Provider: East Texas Medical Center Quitman (ETMC) is a 25-bed, critical access hospital dedicated to serving the Wood County area with advanced diagnostics, medical and surgical care, and outpatient services. ETMC's primary service area is Wood County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 120,272.

Intervention: This project increases access to healthcare through recruiting two primary care providers and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Northern Region (Camp, Franklin, Red River, Wood, and Upshur Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 2,350 (average over three years) new clinic patients with a Medicaid and indigent share of at least 20%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 20% increase in primary care encounters by DY 5, an estimated 2,820 patients. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by recruiting two primary care providers. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by a % increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death.

Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, expanding the clinic staffing will be necessary to cover the additional patients from increased appointment hours. Staffing expansion will include two primary care providers and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services ~~and pediatrics~~. The ETMC Northern Region is currently underserved by 33 primary care providers. ~~physicians—including a shortage of 10 pediatricians~~.

Service Area Population 120,272							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7		29.5	35	33	(2)
Geriatric Medicine	0	0	2.6	2.6	3	1	(2)
Internal Medicine	28.8	17.6		23.2	28	10	(18)
Pediatrics	12.8	12.9		12.9	15	5	(10)
Primary Care Total					**82**	**49**	**(33)**

*2011 Texas Medical Board database

In order to estimate the ~~physician need~~ primary care need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base,

growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering additional physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of approximately 6,000 visits in FY2012.

Rationale: The significance of expanding primary care availability through additional ~~physician~~ staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care ~~physicians~~ providers will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)." Our new ~~physicians~~ providers will provide additional appointment availability to expand access to primary care.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional primary care providers will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how increasing clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: The ETMC Quitman clinic will begin offering additional physician staffing (017624002.1.1) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (017624002.3.1) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

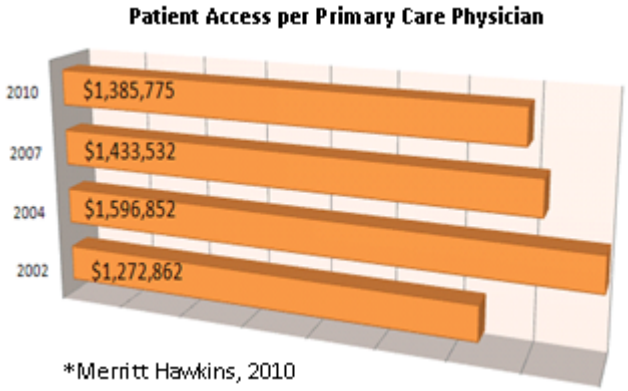
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $696,129 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $640,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Primary Care Capacity		
Total New Clinic Patients		2,467
ED visits / year / person		0.45
Potential ED Visits		1,113
ED Visits Reduced @ 15%		167
Avg ED Payment		$425
ED Savings	**$**	**70,932**
IP Admissions / year / person		0.11
Potential IP Admissions		281
Admissions Reduced @ 18%		51
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**625,197**
Total Estimated Savings	**$**	**696,129**



017624002.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Quitman			*017624002*
Related Category 3 Outcome Measure(s):	***017624002.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-5 Train/hire additional primary care providers and staff and/or increase the number primary care clinics for existing providers. **Metric: 1.1.2.P-5.1** Documentation of increased number of providers and staff and/or clinic sites. **Baseline/Goal:** Increase number of providers and staff over current clinic staffing. **Data Source**: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation **Milestone 1 Estimated Incentive Payment:** $503,799	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 13% [1,880] over baseline of approx 14,000 visits in the Quitman, Mineola & Van RHC's. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $549,617	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 17% [2,350] over baseline of approx 14,000 visits in the Quitman, Minneola & Van RHC's. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $551,215	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 20% [2,820] over baseline of approx 14,000 visits in the Quitman, Minneola & Van RHC's. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $455,352
Year 2 Estimated Total DSRIP: $503,799	Year 3 Estimated Total DSRIP: $549,617	Year 4 Estimated Total DSRIP: $551,215	Year 5 Estimated Total DSRIP: $455,352
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$2,059,983***			

Project Option: 1.9.2 – Improve access to specialty care.
Unique Project ID Number: 020812601.1.1 (Pass 1)
Performing Provider Name/TPI: ETMC Tyler 020812601

Project Abstract

Provider: East Texas Medical Center Tyler (ETMC) is a 454-bed, regional referral hospital dedicated to serving Northeast Texas with advanced diagnostics, medical and surgical care, obstetrical services, and a Level I trauma center. ETMC's primary service area is Smith County, but the secondary service area extends to 15 Northeast Texas counties. The total service area population is estimated at around 862,894.

Intervention: This project increases access to specialty healthcare through recruiting a full-time endocrinologist to establish a specialty clinic location and improve access to diabetes management.

Need for the Project: As sited in the community needs assessment (CN.1, CN.3, CN.4, and CN.5), our region has insufficient access to specialty care services, high rates of chronic disease, high costs due to potentially preventable hospitalizations, and inappropriate emergency room utilization. An endocrinologist will give patients better access to specialty care.

Target Population: The target population is residents of ETMC's 15 county service area in Northeast Texas that currently do not have sufficient access to diabetes or endocrinology care. We expect to serve an average of 2,350 new clinic visits per year with a Medicaid and indigent share of 23%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's specialty care capacity, as evidenced by a ~~12%~~ 2,820 ~~increase in~~ endocrinology clinic visits ~~over baseline~~ by DY 5. Patients will benefit from more appointment availability and expanded specialty access.

Category 3 Outcomes: Through expanded diabetes management access, our new endocrinologist (020812601.1.1) will decrease the percentage of his/her clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% (020812601.3.1). ETMC plans to decrease the percentage of HbA1c poor control (>9.0%) patients —ETMC endocrinology clinic patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: ETMC Tyler's goal is to be able to treat more patients in the specialty care setting where they can receive more appropriate and proactive care, more efficiently. ETMC Tyler plans to expand its specialty care access to providers by recruiting a full-time endocrinologist. The DY 5 goal is to see a 2,820 endocrinology clinic visits, ~~up to a 12% increase over baseline in DY 5.~~

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary and specialty care, preventive care, and chronic disease management. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand specialty care capacity. Expanding specialty care access meets several community needs outlined by RHP 1, including: insufficient access to specialty care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

We will meet the required components of our project through proposing to support access to providers in the underserved area by recruiting an endocrinologist to provide coverage in the Tyler clinics. The new endocrinology clinic location will increase service availability in the Tyler community. In order to maximize efficiency and specialty care access, the clinic will strive to standardize its referrals across the system and conduct quality improvement activities to identify project impacts and opportunities to scale the project to a broader patient population.

Starting point/Baseline: The starting point and baseline for this project consists of our gap analysis and community needs study for endocrinology and diabetes management. A baseline for endocrinology clinic visits will be established in DY 3. A study by The American Journal of Managed Care says that much of the suffering and cost associated with diabetes could be mitigated with appropriate care. However, fewer than 45% of persons with diabetes receive recommended care. This care gap is due to many factors such as inconsistent quality care from healthcare providers, lack of patient education, and lack of support for self-management such as meal planning, weight control, exercise, glucose monitoring, smoking cessation, and medication adherence. Disease management is designed to fill many of the care gaps, and the care is typically provided by an endocrinologist. As the percentage of patients with diabetes continues to grow, ETMC sees the need to recruit an endocrinologist to serve the East Texas community. This is increasingly important as several studies have shown that diabetes disease management programs effectively reduce hospital utilization and cost in various segments of the population.

Rationale: Diabetes is a disease that has reached epidemic proportions across the US and Texas. According to the Kaiser Family Foundation, 9.8% of adults in Texas have been diagnosed with diabetes while 6.2% of all US adults have diabetes. According to the Centers for Disease Control (CDC) in Atlanta, diabetes was the sixth leading cause of death on U.S. death certificates in 2006. Overall, the risk for death among people with diabetes is about twice that of people

without diabetes of similar age. Diabetes is also the leading cause of new cases of blindness, kidney failure, and non-traumatic lower-extremity amputations among adults.

As sited in the community needs assessment (CN.1 and CN.3), recruiting an endocrinologist will help manage chronic disease and create better access to specialty care services. Diabetes is one of the most costly and prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country $100 billion annually. In addition, diabetes accounts for nearly 20% of all deaths in people over 25 years. Amputation, blindness, and kidney failure can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

If current trends continue, 1 in 3 Americans will develop diabetes sometime in their lifetime, and those with diabetes will lose an average of 10-15 years of life. African American, Hispanic, American Indian, and Alaska Native adults are twice as likely as white adults to have diabetes. Therefore, the large Hispanic population is at risk throughout the East Texas communities. The diabetes epidemic is only getting worse, so the recruitment of an endocrinologist is essential to serving the health needs of East Texas.

Related Category 3 Outcome Measures: Through expanded diabetes management access, our new endocrinologist (020812601.1.1) will decrease the percentage of his/her clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

ETMC Tyler plans to engage in project planning for decreasing HbA1c poor control (>9.0%) patients in the new endocrinology clinic during DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for the percentage of HbA1c poor control (>9.0%) patients. ETMC plans to decrease the percentage of HbA1c poor control (>9.0%) patients —ETMC endocrinology clinic patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Relationship to Other Projects: ETMC Tyler plans to implement a Patient Care Navigation Program (020812601.2.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions.

Hiring an endocrinologist (020812601.1.1) provides expansion of services for referred diabetic patients in the ED. The ED triage protocol will create the ability to refer non-urgent patients to the more efficient outpatient clinic setting. Managing the care of diabetic patients will improve

health outcomes and decrease the cost of acute inpatient care. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (020812601.1.2) provides expansion of services for referred behavioral health patients in the ED. The ED triage protocol will create the ability to refer non-urgent, behavioral health patients to the more efficient outpatient and partial hospitalization services.

Expanded cardiology coverage (020812601.1.3) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing 30 day readmissions and lowering the cost of cardiac care. Moreover, expanding care transitions programs (020812601.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will also improve outcomes and decrease 30 day readmissions.

Redesigning to improve the patient experience (020812601.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In a 2010 diabetes disease management study by The American Journal of Managed Care, the intervention group decreased their all-cause total medical costs by $984.87 per member per year (PMPY). They study's conclusion stated that "a disease management program for high-risk patients with diabetes and CAD was effective in reducing hospital inpatient admission and total costs in a Medicare Advantage population."

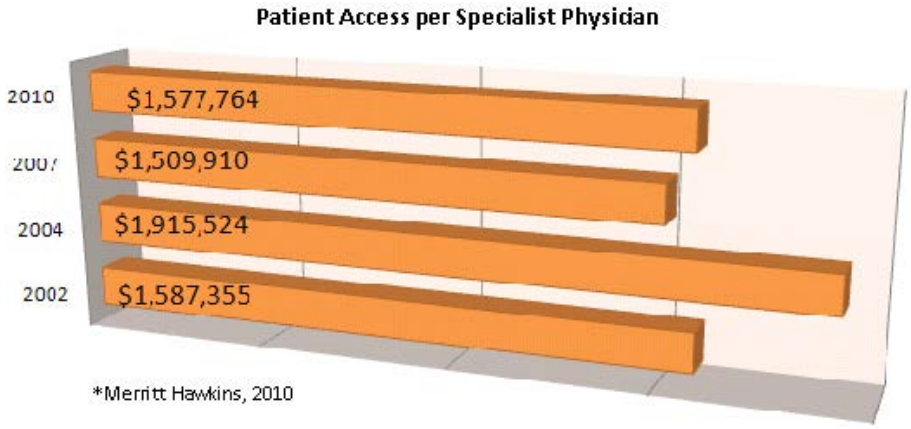
Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a specialist physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional specialist.

The charts below value diabetes management at $1.9M per year and access from a specialist at $1.5M. Accordingly, ETMC's average DSRIP funding request of approximately $1.2M per year

(including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

Estimated Savings from Diabetes Management	
Clinic visits per Year	2,000
Annual Savings per Diabetic patient*	$ 984.87
Estimated Annual Savings	**$ 1,969,740**

*American Journal of Managed Care



(Rosenzweig, et. al. Diabetes Disease Management in Medicare Advantage Reduces Hospitalizations and Costs. *The American Journal of Managed Care.* 2010;16(7):e157-e162)

020812601.1.1	***1.9.2***	***1.9.2.A-D***	**Expand Specialty Care Capacity**
ETMC Tyler			***020812601***
Related Category 3 Outcome Measure(s):	***020812601.3.1***	*3.IT-1.10*	***Diabetes care: HbA1c poor control (>9.0%)***
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.9.2.P-11 Launch/expand a specialty care clinic—endocrinology. **Metric: 1.9.2.P-11.1** Establish/expand specialty care clinics. **Baseline/Goal:** Documentation of new/expanded specialty care clinic **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 1 Estimated Incentive Payment:** $ 930,070	**Milestone 2: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of baseline number of visits. **Baseline/Goal:** Establish a baseline for specialty clinic volume – Estimated at 1880 clinic visits per year – Endocrinology. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $ 1,014,656	**Milestone 3: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 25% (470) increase in endocrinology clinic visits over a baseline of 1880. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $ 1,017,606	**Milestone 4: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 50% (940) increase in endocrinology clinic visits over a baseline of 1880. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $ 840,631
Year 2 Estimated Total DSRIP: $930,070	Year 3 Estimated Total DSRIP: $1,014,656	Year 4 Estimated Total DSRIP: $1,017,606	Year 5 Estimated Total DSRIP: $840,631
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$3,802,962***			

Project Option: 1.9.2 – Improve access to specialty care.
Unique Project ID Number: 020812601.1.2 (Pass 1)
Performing Provider Name/TPI: ETMC Tyler 020812601

Project Abstract

Provider: East Texas Medical Center Tyler (ETMC) is a 454-bed, regional referral hospital dedicated to serving Northeast Texas with advanced diagnostics, medical and surgical care, obstetrical services, and a Level I trauma center. ETMC's primary service area is Smith County, but the secondary service area extends to 15 Northeast Texas counties. The total service area population is estimated at around 862,894.

Intervention: This project increases access to specialty healthcare through establishing cardiology clinics in 5 new, underserved areas.

Need for the Project: As sited in the community needs assessment (CN.1, CN.3, CN.4, and CN.5), our region has insufficient access to specialty care services, high rates of chronic disease, high costs due to potentially preventable hospitalizations, and inappropriate emergency room utilization. Expanded cardiology coverage will give patients better access to specialty care.

Target Population: The target population is residents of the 5 to be determined ETMC counties in Northeast Texas that currently do not have sufficient access to cardiology care. We expect to serve an average of 2,000 new cardiology clinic visits per year with a Medicaid and indigent share of 20%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's specialty care capacity, as evidenced by ~~a~~ 2,500 ~~12% increase in~~ cardiology clinic visits ~~over baseline~~ by DY 5. Patients will benefit from more appointment availability and expanded specialty access.

Category 3 Outcomes: The goal of establishing regional cardiology coverage is to be able to increase the supply of specialty services in several targeted and underserved rural markets while decreasing the CHF 30 day readmission rate. The primary outcome measure that will demonstrate our success toward that goal is to decrease the CHF 30 day re-admission rate by 8% in DY5 for patients in targeted rural markets.

Project Narrative

Project Description: ETMC's goal is to be able to increase the supply of specialty services in several targeted and underserved rural markets. More specifically, ETMC has targeted long term management of cardiology patients as in these rural markets in order to provide care close to home and ultimately avoid costly readmission down the road. Accordingly the four-year target goal is to establish cardiology clinics in 5 new areas. Once a baseline is established, the program seeks continue to increase encounters in subsequent years~~ up to a 12% increase over baseline in DY 5.~~

ETMC proposes to contract with a Tyler based cardiology group to offer regular periodic (i.e. one day per week or similar) cardiology clinics at 5 rural locations that are adjacent to ETMC's rural hospitals. In addition these rural hospitals will provide diagnostic testing infrastructure and capability to ensure that a higher level of a care is provided close to home for these patients.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary and specialty care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand specialty care capacity. Expanding specialty care access meets several community needs outlined by RHP 1, including: insufficient access to specialty care services (CN.1), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

In order to improve access to specialty care in the 5 rural locations, ETMC's project will include the following components: increase service availability with newly available hours; increase number of specialty clinic locations; implement transparent, standardized referrals across the system; and conduct quality improvement by identifying project impacts, opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project.

Starting point/Baseline: A recent report by the Committee on Physician Distribution and Healthcare Access, describes an acute need for specialty care as any specialty where physician need is less than 75% of the US ratio of physicians per 1,000 population. Applying this criteria to the ETMC's service area – a shown in the table below, there is a demonstrated need for a number of physician specialties including Primary care, Cardiology, Pulmonary, Psych, Surgery, OB/GYN, Orthopedics and Urology.

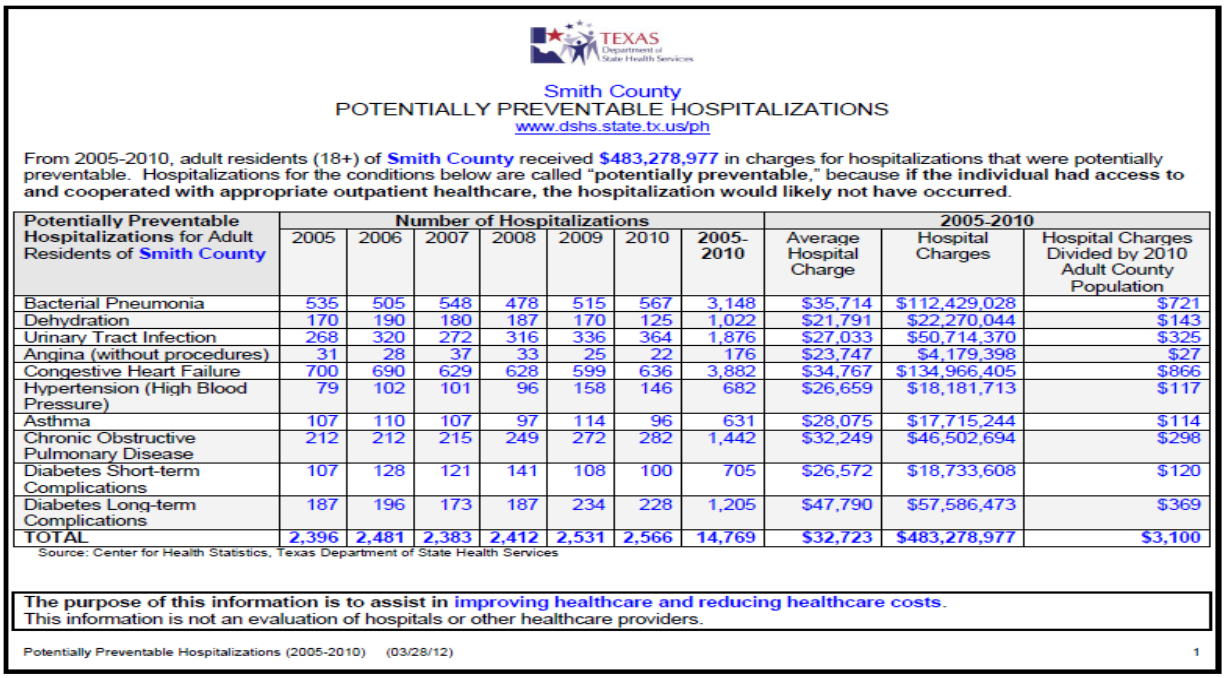
PHYSICIAN SPECIALTY	PHYSICIAN NEED PER 100k	SMITH COUNTY		WEST (Henderson, Kaufmann, Van Zandt)		NORTH (Camp, Franklin, Red River, and Wood)		SOUTH (Anderson, Houston, Trinity)	
	Blended Ratio	Need	501a Presence	Need	501a Presence	Need	501a Presence	Need	501a Presence
Family Practice	29.5	20	17	(19)	5	(1)	7	(5)	3
Geriatric Medicine	2.6	(2)	0	(4)	0	(1)	1	1	2
Internal Medicine	23.2	5	8	(47)	0	(13)	2	(11)	1
Pediatrics	12.9	2	8	(23)	2	(6)	2	(7)	1
Primary Care		**25**	**32**	**(93)**	**7**	**(21)**	**12**	**(23)**	**7**
Cardiology	3.5	24	2	(5)	0	(2)	1	(2)	0
Physical Medicine	1.1	21	5	(3)	0	1	0	1	0
Psychiatry	13.0	(8)	5	(5)	0	(11)	0	(11)	0
Pulmonology	1.5	11	0	(4)	0	(1)	0	(1)	0
Medical Specialties		**48**	**12**	**(17)**	**0**	**(13)**	**1**	**(13)**	**0**
General Surgery	11.7	1	5	(22)	0	(4)	0	(6)	0
OB/GYN	10.5	6	0	(16)	0	(7)	2	(3)	1
Orthopedic Surgery	5.8	20	4	(9)	3	(4)	1	(3)	0
Urology	3.1	10	5	(6)	0	(2)	0	(1)	0
Surgical Specialties		**36**	**14**	**(52)**	**3**	**(17)**	**3**	**(14)**	**1**
Emergency	5.8	27	14	0	0	3	0	0	0
Hospitalist	2.7	6	0	(6)	0	(2)	0	(1)	0
Hospital-Based		**33**	**14**	**(6)**	**0**	**1**	**0**	**(0)**	**0**
TOTAL		**142**	**72**	**(168)**	**10**	**(51)**	**16**	**(50)**	**8**

It is also noted that the service area has an oversupply of specialists in the urban Smith County area and a shortage of specialists in the rural west, north and south markets. While it has always been desirable to push care back to the local markets, volume is not typically sufficient to support specialty physician coverage in these areas. The problem has been compounded by a reimbursement system that pays physicians on volume rather than value basis.

Rationale: Historically, smaller rural markets in ETMC's service area have had a difficult time recruiting and retaining specialists, especially in the areas of cardiology. From time to time, larger Tyler based cardiology groups have offered some clinics in those areas, but coverage has been inconsistent. Moreover, most if not all of the diagnostic testing has been done in physician offices in Tyler, thus requiring cardiology patients to drive long distances to receive care, thus leading to underutilization of preventative care and repeated readmissions. Moreover, as sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to specialty care. In a recent article, Rumsfeld et al have argued that while the reasons for hospital readmission are a "complex, multi-factorial outcome measure, and it remains unclear how hospital readmission rates can effectively and safely be lowered." They go on to suggest that "the answer lies in improving institutional quality of care."

(John S. Rumsfeld, MD, PhD; Larry A. Allen, MD, MHS, "Reducing Cardiac Readmission Rates, Does Coronary Artery Bypass Graft Surgery Provide Clarity"*J Am Coll Cardiol Intv*. 2011;4(5):577-578. doi:10.1016/j.jcin.2011.04.002)

As shown in the chart below, The Texas Department of State Health Services suggests that in Smith County alone there were approximately 14,769 potentially preventable hospitalizations from 2005-2010. These patients represented more than $483M in charges. Of those patients, almost 42% had cardiology related diagnoses of angina, CHF, Hypertension or COPD. It is estimated that an equal number of patients could be impacted in the surrounding counties.



Smith County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Smith County** received **$483,278,977** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of Smith County	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	2005-2010	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	535	505	548	478	515	567	3,148	$35,714	$112,429,028	$721
Dehydration	170	190	180	187	170	125	1,022	$21,791	$22,270,044	$143
Urinary Tract Infection	268	320	272	316	336	364	1,876	$27,033	$50,714,370	$325
Angina (without procedures)	31	28	37	33	25	22	176	$23,747	$4,179,398	$27
Congestive Heart Failure	700	690	629	628	599	636	3,882	$34,767	$134,966,405	$866
Hypertension (High Blood Pressure)	79	102	101	96	158	146	682	$26,659	$18,181,713	$117
Asthma	107	110	107	97	114	96	631	$28,075	$17,715,244	$114
Chronic Obstructive Pulmonary Disease	212	212	215	249	272	282	1,442	$32,249	$46,502,694	$298
Diabetes Short-term Complications	107	128	121	141	108	100	705	$26,572	$18,733,608	$120
Diabetes Long-term Complications	187	196	173	187	234	228	1,205	$47,790	$57,586,473	$369
TOTAL	2,396	2,481	2,383	2,412	2,531	2,566	14,769	$32,723	$483,278,977	$3,100

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Related Category 3 Outcome Measures: The goal of establishing regional cardiology coverage (1.9.2) is to be able to increase the supply of specialty services in several targeted and underserved rural markets while decreasing the CHF 30 day readmission rate. More specifically, ETMC has targeted long term management of cardiology patients as in these rural markets in order to provide care close to home and ultimately avoid costly readmission down the road.

ETMC proposes to contract with a Tyler based cardiology group to offer regular periodic (i.e. one day per week or similar) cardiology clinics at 5 rural locations that are adjacent to ETMC's rural hospitals. In addition these rural hospitals will provide diagnostic testing infrastructure and capability to ensure that a higher level of a care is provided close to home for these patients.

The primary outcome measure that will demonstrate our success toward that goal is to decrease the CHF 30 day re-admission rate by 8% in DY5 for patients in targeted rural markets.

Relationship to Other Projects: ETMC Tyler plans to implement a Patient Care Navigation Program (020812601.2.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions.

Hiring an endocrinologist (020812601.1.1) provides expansion of services for referred diabetic patients in the ED. The ED triage protocol will create the ability to refer non-urgent patients to

the more efficient outpatient clinic setting. Managing the care of diabetic patients will improve health outcomes and decrease the cost of acute inpatient care. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (020812601.1.2) provides expansion of services for referred behavioral health patients in the ED. The ED triage protocol will create the ability to refer non-urgent, behavioral health patients to the more efficient outpatient and partial hospitalization services.

Expanded cardiology coverage (020812601.1.3) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing 30 day readmissions and lowering the cost of cardiac care. Moreover, expanding care transitions programs (020812601.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will also improve outcomes and decrease 30 day readmissions.

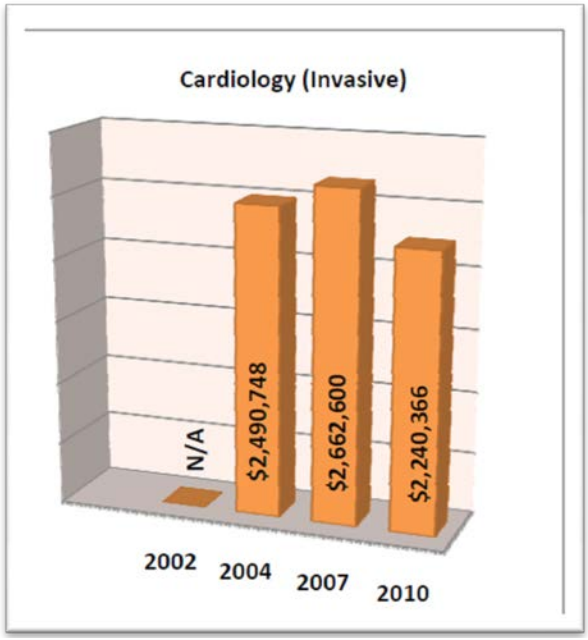
Redesigning to improve the patient experience (020812601.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a cardiologist on behalf of his/her affiliated hospital.

The study suggests a value of $2.2M per year. Accordingly, ETMCRHS's average DSRIP funding request of $1.8M per year is targeted to be less than the value of cardiology access expansion so that the Medicare program accrues a net benefit.


Cardiology (Invasive)
N/A
$2,490,748
$2,662,600
$2,240,366
2002
2004
2007
2010

020812601.1.2	***1.9.2***	***1.9.2.B***	**Increase number of specialty clinic locations**
ETMC Tyler			*020812601*
Related Category 3 Outcome Measure(s):	***020812601.3.2***	*3.IT-3.2*	*Congestive Heart Failure 30 day re-admission rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.9.2.P-11 Launch/expand a specialty care clinic. **Metric: 1.9.2.P-11.1** Establish/expand specialty care clinics. **Baseline/Goal:** Establish clinics in 5 target markets and begin to see patients. **Data Source**: Documentation **Milestone 1 Estimated Incentive Payment:** $ 1,521,235	**Milestone 2: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Establish a baseline for specialty clinic volume – number of visits. **Baseline/Goal:** Establish a baseline for specialty clinic volume. Estimated at 1500 clinic visits per year across all coverage locations. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $ 1,659,586	**Milestone 3: 1.9.2.I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 33% (500) increase in cardiology clinic visits over a baseline of 1500. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $ 1,664,410	**Milestone 4: 1.9.2.I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 66% (1000) increase in cardiology clinic visits over a baseline of 1500. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $ 1,374,948
Year 2 Estimated Total DSRIP: $1,521,235	Year 3 Estimated Total DSRIP: $1,659,586	Year 4 Estimated Total DSRIP: $1,664,410	Year 5 Estimated Total DSRIP: $1,374,948
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$6,220,179***			

Project Option: 1.9.2 – Improve access to specialty care.
Unique Project ID Number: 020812601.1.3 (PASS 1)
Performing Provider Name/TPI: ETMC Tyler 020812601.1.3

Project Abstract

Provider: East Texas Medical Center Tyler (ETMC) is a 454-bed, regional referral hospital dedicated to serving Northeast Texas with advanced diagnostics, medical and surgical care, obstetrical services, and a Level I trauma center. ETMC's primary service area is Smith County, but the secondary service area extends to 15 Northeast Texas counties. The total service area population is estimated at around 862,894.

Intervention: This project will support specialty care access to behavioral health providers in the underserved area by recruiting a full-time psychiatrist for outpatient and partial hospitalization services.

Need for the Project: As sited in the community needs assessment (CN.2, CN.4, and CN.5), our region has insufficient access to behavioral care services, high costs due to potentially preventable hospitalizations, and inappropriate emergency room utilization. A psychiatrist for outpatient and partial hospitalization services will give patients better access to specialty care.

Target Population: The target population is residents of ETMC's 15 county service area in Northeast Texas that currently do not have sufficient access to behavioral health outpatient and partial hospitalization services. We expect to serve approximately 750 new clinic patients per year with a Medicaid and indigent share of 23%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's behavioral health outpatient and partial hospitalization capacity, as evidenced by a 50% increase in volume over baseline by DY 5, an estimated 1,000 new patients served. Patients will benefit from expanded access to behavioral health services.

Category 3 Outcomes: The outcome measure for the new psychiatrist assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

Rate 1 - The percentage of members who received follow-up within 30 days of discharge
Rate 2 - The percentage of members who received follow-up within 7 days of discharge

ETMC plans to increase the number of patients who received follow-up within 30 days and 7 days of discharge by 4% and 8% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: We propose to support specialty care access to behavioral health providers in the underserved area by recruiting a full-time psychiatrist for outpatient and partial hospitalization services. ETMC Tyler's goal is to be able to treat more patients in the behavioral health setting where they can receive appropriate and proactive care, more efficiently. ETMC Tyler plans to expand its specialty care capacity of behavioral health access to providers by recruiting a full-time psychiatrist to focus on outpatient and partial hospitalization services. The five-year goal is to increase outpatient clinic visits and partial hospitalization admissions by 50% over baseline (FY12).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary, specialty, and behavioral health care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand specialty care capacity. Expanding specialty care access meets several community needs outlined by RHP 1, including: insufficient access to behavioral care services (CN.2), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

We will meet the required components of our project through proposing to support access to providers in the underserved area by recruiting a psychiatrist to provide coverage in the Tyler clinics. The new psychiatry clinic location will increase service availability in the Tyler community. In order to maximize efficiency and specialty care access, the clinic will strive to standardize its referrals across the system and conduct quality improvement activities to identify project impacts and opportunities to scale the project to a broader patient population.

Starting Point/Baseline: ETMC conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for physicians in several markets; specifically, the ETMC Central Region (Smith County) is currently underserved by 8 psychiatrists. ETMC Tyler responded to the behavioral health shortage by providing a variety of inpatient and outpatient services at ETMC Behavioral Health Center; however, outpatient and partial hospitalization services remain in high demand and low supply. The critical shortage of mental health providers has led to outpatient visit wait times of three months. As a part of the Central Region, ETMC Tyler plans to recruit a full-time psychiatrist to provide outpatient and partial hospitalization services.

Service Area Population 206,033						
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)				PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	Blended Ratio	Population	All Physicians*	2012
Psychiatry	15.9	10.0	13.0	27	19	(8)

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony and data to model physician need based on current physician supply by specialty, and whether it is adequate given the population base, growth, and future demand. It is a collaborative approach by a range of experts that utilizes comprehensive data sources. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand. This methodology is ideal for projecting needs and uses well regarded source data (MGMA, NAHCMS).

FY12 Baseline Outpatient Visits	
Visits per week	40
Weeks per year	48
FY12 Visits	**1920**

FY12 Baseline Partial Hospitalization Admissions	
Admits per month	20
Months per year	12
FY12 Admissions	**240**

Rationale: Historically, resources for behavioral health services have been limited across the country. In line with the national trends, the RHP community needs assessment cited a critical shortage of behavioral health providers that leads to inappropriate ED utilization (CN.2 and CN.5) as a concern in its region. There is an imbalance of demand and supply of behavioral health services due to the shortage of providers and the nationally delayed development of mental health interventions. Without regular access to these services, conditions are likely to become acute episodes—putting patients at risk for disability and long term illness. The lack of behavioral health providers has a significant negative impact on patient satisfaction and quality of care and discourages people from using health care proactively.

Expansion of behavioral health services is crucial for the national healthcare system to complete the entire continuum of care. The historic lack of providers and attention to mental health needs has created a serious shortage of behavioral health services. While ETMC has used its Behavioral Health Center to take the lead on behavioral services, there is still a significant shortage for outpatient and partial hospitalization services. With expanded behavioral health access, more patients will have the opportunity to treat episodes early, maintain follow up care, and prevent future inpatient utilization. Recruitment of a psychiatrist will be another step in providing better mental health access to an underserved population.

According to the Association for Ambulatory Behavioral Healthcare (AABH), partial hospitalization is the part of the mental health continuum that combines the best facets of

inpatient care with the best of outpatient care. Partial hospitalization is an avenue of providing clinically equivalent mental healthcare at a much lower cost than inpatient treatment.

Related Category 3 Outcome Measures: We propose to support access to behavioral health providers in the underserved area by recruiting a full-time psychiatrist for outpatient and partial hospitalization services. This outcome measure for the new psychiatrist assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

Rate 1 - The percentage of members who received follow-up within 30 days of discharge
Rate 2 - The percentage of members who received follow-up within 7 days of discharge

ETMC Tyler plans to engage in project planning in DY 2 to provide follow-up services after hospitalization for behavioral health patients by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for increasing follow-up after hospitalization for mental illness. ETMC plans to increase the number of patients who received follow-up within 30 days and 7 days of discharge by 4% and 8% in demonstration years 4 and 5, respectively.

Relationship to Other Projects: ETMC Tyler plans to implement a Patient Care Navigation Program (020812601.2.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions.

Hiring an endocrinologist (020812601.1.1) provides expansion of services for referred diabetic patients in the ED. The ED triage protocol will create the ability to refer non-urgent patients to the more efficient outpatient clinic setting. Managing the care of diabetic patients will improve health outcomes and decrease the cost of acute inpatient care. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (020812601.1.2) provides expansion of services for referred behavioral health patients in the ED. The ED triage protocol will create the ability to refer non-urgent, behavioral health patients to the more efficient outpatient and partial hospitalization services.

Expanded cardiology coverage (020812601.1.3) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing 30 day readmissions and lowering the cost of cardiac care. Moreover, expanding care transitions programs (020812601.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will also improve outcomes and decrease 30 day readmissions.

Redesigning to improve the patient experience (020812601.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: AABH studies have shown a direct savings of 40-60% over inpatient benefits. There are also indirect savings of partial hospitalization and outpatient services because an employee may be able to work on at least a limited basis, thus maintaining productivity. Furthermore, there is evidence that those who successfully complete partial hospitalization treatment generally will require less treatment in the future.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a psychiatrist on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional psychiatrist.

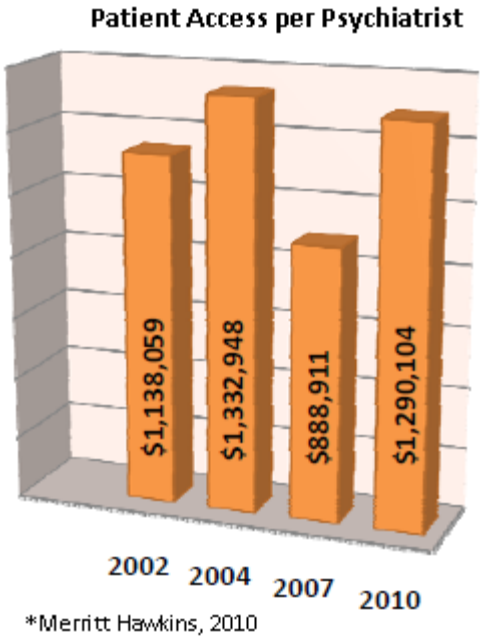
The charts below value outpatient and partial hospitalization services at $1.47M per year and access from a psychiatrist at $1.29M. Accordingly, ETMC's average DSRIP funding request of approximately $1M per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

Estimated Savings Expansion of Outpatient and Partial Hospitalization	
Estimated Patients Served	750
ED Visits per SMI patient[1]	0.84
ED Visits	630
Prevented ED Visits @ 60% Reduction	**378**
ED Cost per Psych Patient[2]	$ 2,264
ED Savings	**$ 855,792**
Inpatient Admissions per SMI patient[1]	0.20
Inpatient Admissions	150
Prevented Admissions @ 60% Reduction	**90**
Inpatient Psych ALOS	10
Cost per Inpatient Psych day[3]	$ 685
Inpatient Savings	**$ 616,509**
Total Estimated Savings	**$ 1,472,301**

1) *Emergency Medicine International* , 2012

2) CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011

3) National Alliance on Mental Illness



020812601.1.3	***1.9.2***	***1.9.2.A-D***	**Expand Specialty Care Capacity**
ETMC Tyler			***020812601***
Related Category 3 Outcome Measure(s):	***020812601.3.3***	*3.IT-1.18*	***Follow-Up After Hospitalization for Mental Illness***
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.9.2.P-11 Expand a specialty care clinic—psychiatry. **Metric: 1.9.2.P-11.1** Establish/expand specialty care clinics. **Baseline/Goal:** Documentation of new/expanded specialty care clinic **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 1 Estimated Incentive Payment:** $ 796,006	**Milestone 2: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 25% [500] increase in outpatient clinic and partial hospitalization visits over baseline of 2000 visits per year. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $ 868,400	**Milestone 3: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 38% [750 increase in outpatient clinic and partial hospitalization visits over baseline of 2000 visits per year. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $ 870,925	**Milestone 4: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 50% [1000] increase in outpatient clinic and partial hospitalization visits over baseline of 2000 visits per year. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $ 719,459
Year 2 Estimated Total DSRIP: $796,006	Year 3 Estimated Total DSRIP: $868,400	Year 4 Estimated Total DSRIP: $870,925	Year 5 Estimated Total DSRIP: $719,459
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$3,254,790***			

Project Option: 1.11.2 – Implement technology assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.
Unique Project ID Number: 084434201.1.1 (Pass 1)
Performing Provider Name/TPI: Texoma Community Center 084434201

Project Abstract

Brief Provider Description: Texoma Community Center is a governmental entity known as a Local Mental Health Authority (LMHA) serving three rural counties in North Central Texas covering 2,698.4 square miles. Fannin County has a 2011 census of 33,358 people representing 1% increase from the previous year. (1a) TCC has four primary clinics providing a monthly average of 10,226 face to face services (1b) to over 1,200 adults, children, and families ranging in age from birth to death. Less than 1% of TCC's patients have private insurance, 38% have Medicaid, and 81.34% of adult patients are below the federal poverty level.

Interventions: This project enhances access through telemedicine services and electronic health records (EHR) for TCC patients residing in RHP 1 by expanding psychiatric appointments, psychosocial rehabilitation, skills training, case management, mental health assessments, counseling and crisis intervention for adults and children.

Need for the Project: TCC selected this project to expand and improve medical and behavior health services in RHP 1. Fannin County is identified by HRSA as an underserved behavioral health provider area. (1c) Both expanded telemedicine options and an EHR system will improve TCC's ability to provide prompt, clinically efficient and appropriate services to a broader patient base. Finkelstein, et. al., (2012) said: "Ninety-two studies evaluated the impact of health IT applications on clinical outcomes. . . . Overall, we found that various health IT applications implemented to enhance PCC [patient centered care] generally improved clinical outcomes for patients with diabetes, heart disease, cancer, and other health conditions, and several of these interventions showed a statistically significant favorable impact." (1d) Please note that TCC has NOT received federal funding for telehealth or EHR systems.

Target Population: The target population for Project 084434201.1 consists of indigent patients needing psychiatric care, skills training, case management, education training and support, biopsychosocial assessments, counseling and crisis intervention in the community where telemedicine capabilities can be established, such as in emergency departments.

Category 1 or 2 Expected Patient Impact/Benefits: TCC currently uses telemedicine services in the Child and Adolescent Program for psychiatric appointments only, averaging 52 telehealth encounters center-wide per month, including 62 children in Fannin County. The DY 2 goal is to procure additional telemedicine equipment. DY 3 goal is to select 1 additional telemedicine site, install the equipment and have staff fully trained. Telemedicine services will be expanded in this region to different types of services, for a DY 4 goal of 75 patients and a DY 5 goal of 88 patients. Overall, patient impact is for 163 new patients to receive benefit from this $199,496.00 project by DY 5. (9c, 9d) Also, TCC expects for 20% to be new patients receiving substance abuse treatment in DY 4 and 25% in DY 5.

***Category 3 Outcomes*:** TCC's Category 3 Outcome goal is IT 10.1 Quality of Life which research has shown reduces ED visits and health care costs for target populations. Category 3 targets will be determined in DY 2 *since this is a new service so numbers are not available until after the first year of the project. At that time metrics will be established to address specific numbers of the population whose utilization is an expected benefit of this project.*

Project Title: 1.11 -- Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services

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

Required core project components:

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

Project Narrative

Project Description:

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

Wisconsin Population Health Institute's 2012 County Health Rankings shows Fannin County has a ratio of 16,509 residents to 1 health provider.(11) TCC agrees that modern communications technology holds the greatest promise of bridging the gap between medical need in underserved areas and the provision of needed services (CN.2, CN.5). The State of Texas has 195 counties (77% of all Texas counties) that have been designated by the US Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs) and all three of TCC's three-county service area fall in this category as being underserved in the area of behavioral health. (1c)

TCC's goal to use internet-based communications will extend services to more individuals through high quality, real time technology. This will require TCC to provide additional technological infrastructure development by enhancing the telecommunications system in all TCC facilities, adding an Electronic Health Record system, and installing additional telehealth equipment in expanded service sites. TCC proposes to use telecommunications for new initiatives that will include mental health assessments, treatment, education, monitoring, mentoring and collaboration, in addition to the existing psychiatric treatment which will also be expanded to include additional patients. This expansion project is absolutely essential to improve TCC's treatment quality, reduce risk of harm, and improve cost-effectiveness, efficiency, accuracy, and access to behavioral health treatment. TCC's goals also help meet RHP 1 regional goals, specifically to improve access to health care services and to improve quality of care and patient satisfaction.

In order to meet these goals, all **core components** will be addressed in that TCC will: (1) develop appropriate administrative and clinical protocols for all telecommunication services; (2) determine if a pilot project is needed and engage in rapid-cycle improvement strategies; (3) will utilize the staff already employed and trained in telemedicine services, plus add and train new staff, to be successful in meeting the provider and regional goals; (4) utilize and adapt current modifiers used to tracks encounters and add new ones as needed as part of the utilization management and quality improvement endeavors; (5) develop and implement improved data management and reporting standards; (6) review and evaluate the impact these services have on specialty care and be able to identify and share the "lessons learned"; (7) "scale up" program as warranted to serve a larger patient population through telehealth services as efficiencies are recognized; and (8) engage in a continuous quality improvement process to determine pertinent patient outcomes.

The projected five year outcome will be to have a broader telehealth system that serves added low-income individuals in the service area through telemedicine/telemonitoring/telementoring sites for therapy, internship supervision, substance abuse treatment, and additional children's psychiatrist time. TCC further expects to have improved functioning and better access to care through an organized Electronic Health Records (EHR) system and improved overall communications system, that will: "Improve quality, safety, and efficiency of health care to reduce health disparities" as outlined by the MU [Meaningful Use] Press Release of April 18, 2011 evaluating the Electronic Health Record Meaningful Use initiative. (14) These internal center improvements will, in turn, improve health care provision in the RHP 1 region by enhancing quality and expanding capacity.

Starting Point/Baseline: TCC has four primary clinics in a three county area providing treatment to over 1,200 adults, children, and families with severe and persistent mental illnesses, co-occurring substance abuse issues, emotional disturbances, and/or developmental delays with an average of 10,226 face to face contacts per month. The child and adolescent psychiatrists serve over 140 individuals and families, over-serving by 103%. (15) In the Child and Adolescent Department, access to psychiatric care is exclusively through telemedicine and currently both the telemedicine and face to

face services are limited by a paper/chart system where access to vital patient information is delayed, clerical staff time is wasted by scanning and uploading patient data from charts for physician access, and clinician time is regularly wasted by inability to access critical patient data on an immediate basis. TCC has received no funding of any type, including federal funding, for implementing an Electronic Health Record system. The current telecommunications system is degraded to the point that all telemedicine contact is frequently disrupted and telephone calls are dropped and/or static-laden on a daily basis for all staff, including Crisis Team staff handling potentially life-threatening emergency calls. TCC employs 138 individuals who provide or support services to these 1,200+ people as well as other citizens in Cooke, Grayson and Fannin counties who are in crisis. Patient safety is compromised by the current telecommunications system, especially in the midst of a crisis call where there is potential for risk of harm with a suicidal patient if consistent, clear contact is not maintainable.

TCC provides telemedicine services to approximately 122 children and adolescents, 62 of whom reside in RHP 1, so 62 will be the baseline for expansion in this region. LMHA's, specifically TCC, have not received federal funding for EHR systems.

Rationale: Texoma Community Center selected this broad project in order to move our services firmly into the future. In RHP 1, a primary need has been identified (CN.2) regarding insufficient access to physician and behavior health services in Fannin County. In order to address these needs and enhance service improvement, overhauling the telecommunications infrastructure will be necessary. Upgrading and expanding the electronic and communications infrastructure will vastly improve patient safety, enhance communication as well as continuity of care for patients while allowing for more patients to be served with better quality care.

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

These improvements to the system will allow TCC to thus improve efficiency and have a reliable communication infrastructure that will improve contact quality through a comprehensive telehealth system. The RHP 1 and TCC service area is identified by HRSA as an underserved area in behavioral health services and there is a significant community need to expand all behavioral health services, especially for those with severe and persistent mental illness, substance abuse problems, or those with

co-occurring physical health disorders (CN.2). This project is essential to improve treatment quality, reduce risk of fraud, improve patient satisfaction, and enhance the quality, efficiency, accuracy, and access to medical and/or treatment data for individuals accessing public mental health in extremely under-funded, rural service areas (CN.2, CN.3, CN.4).

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

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

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

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

[patient centered care] generally improved clinical outcomes for patients with diabetes, heart disease, cancer, and other health conditions, and several of these interventions showed a statistically significant favorable impact." (19)

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

Relationship to other Projects*:* This project will enhance overall service availability and broaden the range of services for three of the other projects submitted by our RHP, specifically those related to substance abuse (1.1.1), counseling (1.1.2), expanding behavioral health care and combining primary care and behavioral health care (1.2.1). These services will be more effective and efficient when supported by improved telehealth/telemedicine technologies which will allow for more accurate, timely and cost-effective continuity of care and collaboration. EHR and Telemedicine additions and expansions will facilitate an integrated healthcare model (1.2.1) to allow for both physical and behavioral health issues to be addressed efficiently, while broadening access to unfunded and underserved individuals within our community (CN.2).

Relationship to Other Performing Providers' Projects in the RHP: Texoma Community Center's Telehealth Project supports, reinforces and relates to the other projects and providers in RHP 1 by enhancing collaboration, sharing data and information, as well as engendering referrals as appropriate. TCC has designed projects that fulfill the community needs (CN.1, CN.2, CN.4, CN.5, and CN.6). There are no specific TCC projects that are combined in implementation with other providers in the region, but all TCC projects will contribute to the RHP 1 initiatives through collaboration and sharing data, expanding knowledge and experiences with other providers in RHP 1 and expand services in order to enhance best-practice models throughout the region. TCC will communicate directly with providers to enhance services, such as Lakes Regional MHMR for both substance abuse treatment and counseling projects. Our projects meet specific needs for the underserved in our area, and will not duplicate services since the needs far exceed provider capacity in this region (CN.2).

Plan for Learning Collaborative Plan for Learning Collaborative: The RHP 1 Anchor will develop and convene the Learning Collaborative opportunities with input from the regional providers. This opportunity to regularly exchange knowledge and experiences related to progress with DSRIP projects will facilitate success throughout the region. TCC will participate in the RHP-1 learning collaborative with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes and to facilitate success throughout the region. This project will significantly improve TCC's ability to share information and experiences in a collaborative way with others by recording patient information rapidly. This experience will help direct TCC's growth and expansion toward even more cost-effective, evidence-based practices. One goal of participating in the learning collaborative will be to identify and expand the projects to a broader patient population.

Project Valuation: TCC recognizes the need for a front-end high-cost technological infrastructure development that will rapidly increase overall community and patient value by providing rapid information and provider treatment access. This initial cost will, however, reduce operational costs over an indefinite period of time. Principal patient benefactors of the improved telecommunication system will be people who are uninsured, under-insured, or have Medicaid. The project will produce

higher quality behavioral/medical care through patient-centered telemedicine treatment, collaborative stakeholder communications, and expedited input and access of secure electronically transmitted and stored information. TCC's service area is comprised of a sparsely populated rural geographical area that has four, almost equally distanced nuclear communities, which is a natural barrier to expanding service. Service access has been identified as a recognized community need (CN.2), such that rapid access to care is not currently a reasonable/obtainable outcome. Quick access to electronically stored information, video-conferencing among collaborating stakeholders, and telemedicine treatment for patients is an attractive option and viable solution for access to care in the area because most patients can be transported to one of the four relatively convenient locations where the telehealth services can connect them to providers. TCC will look, as has been its practice, to support from foundations and fund raisers, other collaborating stakeholders, and third-party billing sources as local funding that will help sustain a greatly improved service delivery system.

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

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

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A search of the scientific literature identified the following two studies as supporting this valuation methodology. The first study Brown, Alamgir & Bohman (2012) (9a) identified looking at telemedicine and mental health was conducted by Pyne (2010) which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. (9c) Another study by Hollinghurst et al (2010) examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. (9d) The average of the two estimated QALYs is 0.0245. This project value is $199,496.00 and it is expected to benefit 163 people in the RHP 1 area.

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1-P-4 – Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment P-4.1 Metric: Inventory of new equipment purchased Baseline: No equipment purchased Goal: Necessary equipment purchased Data Source: Purchase Orders/Receipts Milestone 1 Estimated Incentive Payment (maximum amount): $45,257.00	Milestone 2-P-6- Establishment of Remote Site Locations where equipment/software will be available to consumers P-6.1 Metric: Documentation of completion of site acquisition/remodel Baseline: No documentation in place Goal: Purchase/contractor/lease documentation in place Data Source: Purchase/contractor receipts/financial records Milestone 2 Estimated Incentive Payment (maximum amount): $24,850.00		Milestone 4-P-9- Develop operations manual of telemedicine or telehealth with protocols and clinical guidelines P-9.1 Metric: Documentation of completion of manual and of use of manual in training sessions of providers/peers Baseline: No documentation of operations manual in place Goal: Documentation of operations manual in place and evidence it is being used in training. Data Source: Operations manual with written protocols and guidelines Milestone 4 Estimated Incentive Payment (maximum amount): $13,292.00 Milestone 5-P-11- Individuals residing in underserved areas that have used telemedicine, telehealth,	Milestone 8-P-11- Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and/or telemonitoring services for treatment of mental illness / substance use disorders P-11.1Metric: Increase the number of individuals residing in underserved area of the health partnership region who have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness / substance use disorders. Baseline: 62 current patients. Numerator: Number of individuals served by TCC residing in underserved areas that have used telemedicine, telehealth,

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 3-P-8- Continue Training for providers / peers on use of equipment / software P-8.1 Metric: Documentation of completions of training on use of equipment / software Baseline: Zero staff trained Goal: 75% staff trained Data Source: Training Rosters Milestone 3 Estimated Incentive Payment (maximum amount): $24,851.00	telementoring, and/or telemonitoring services for treatment of mental illness / substance use disorders P-11.1Metric: Increase the number of individuals residing in underserved area of the health partnership region who have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness / substance use disorders. Baseline: 62 current patients. Numerator: Number of individuals served by TCC residing in underserved areas that have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders Denominator: Number of individuals residing in underserved area of health partnership region who have received	telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders Denominator: Number of individuals residing in underserved area of health partnership region who have received treatment for mental illness or substance use disorders. Goal: Increase number of individuals residing in underserved areas served by TCC that have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders to 88 new patients in DY 5 Data Source: Encounter and Claims data (based on coding DSHS modifiers or HCPC's level II

084434201.1.1	Project Option 1.11.2	Project Components: 1.11.2.a-h	Implement technology-assisted Services (Telehealth, Telemonitoring, Telementoring, or Telemedicine) to support, coordinate, or deliver behavioral health services	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			treatment for mental illness or substance use disorders. Goal: Increase number of individuals residing in underserved areas served by TCC that have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness or substance use disorders to 75 new patients in DY 4 Data Source: Encounter and Claims data (based on coding DSHS modifiers or HCPC's level ll Modifiers) Milestone 5 Estimated Incentive Payment (maximum amount): $13,292.00 Milestone 6: P-14 – Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to	Modifiers) Milestone 8 Estimated Incentive Payment (maximum amount): $37,978.00 Milestone: 9- I–18 – Improve access to substance abuse treatment for individuals residing in underserved areas that have used telemedicine, telehealth, and/or telemonitoring services. I-18.2 Metric: – Increase percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an outpatient telehealth or telemedicine visit within 14 days of the diagnosis and who initiated treatment AND who

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-14.1 Metric: – Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No documented participation in meetings. Goal: Two documented regional meetings attended by staff. Data Source: Documentation of semiannual meetings including meeting agenda, slides from presentations, and/or meeting notes. Rationale/Evidence: The highest	had two or more additional services with an AOD diagnosis within 30 days of the initial visit. Baseline: 62 current telemedicine patients Numerator: Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD and had two or more additional services with an AOD diagnosis within 30 days of the initial telemedicine or telehealth visit. Denominator: Patients aged 13 years and older with a new episode of alcohol and other drug (AOD) dependence who are referred for telemedicine, telehealth, or telemonitoring services. Goal: 25% increase in telemedicine patients (16) initiated

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-14.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives identified. Goal: Initiatives identified and being implemented. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central	and are receiving substance abuse treatment. Data Source: Encounter Data Data Milestone 8 Estimated Incentive Payment (maximum amount): $51,370.00

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 6 Estimated Incentive Payment (maximum amount): $13,292.00 Milestone 7- I-18: Improve access to substance abuse treatment for individuals residing in underserved areas that have used telemedicine, telehealth, and/or telemonitoring services. I-18.2 Metric: Increased percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate	

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			treatment through an out-patient telehealth or telemedicine visit within 14 days of the diagnosis or who initiated treatment AND who had two or more additional services with an AOD diagnosis within 30 days of the initial visit. Baseline: 62 current patients Numerator: Patients who initiated treatment within 14 days of the initial diagnosis of AOD or intervention for AOD and had two or more additional services with an AOD diagnosis within 30 days of the initial telemedicine or telehealth visit. Denominator: Patients ages 13 years or older with a new episode of alcohol and other drug (AOD) dependence who are referred for telemedicine, telehealth, or telemonitoring services. Goal: 20% increase In telemedicine patients (12) initiated and are receiving	

084434201.1.1	PROJECT OPTION 1.11.2	PROJECT COMPONENTS: 1.11.2.A-H	IMPLEMENT TECHNOLOGY-ASSISTED SERVICES (TELEHEALTH, TELEMONITORING, TELEMENTORING, OR TELEMEDICINE) TO SUPPORT, COORDINATE, OR DELIVER BEHAVIORAL HEALTH SERVICES	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.1	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			substance abuse treatment. Milestone 7 Estimated Incentive Payment: $13,292.00	
Year 2 Estimated Milestone Bundle Amount:$45,257.00	Year 3 Estimated Milestone Bundle Amount: $ 49,701.00		Year 4 Estimated Milestone Bundle Amount: $53,168.00	Year 5 Estimated Milestone Bundle Amount: $51,370.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $199,496.00				

Project Option: 1.12.2 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas.
Unique Project ID Number: 084434201.1.2 (Pass 1)
Performing Provider Name/TPI: Texoma Community Center 084434201

Project Abstract

Provider: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC has a clinic in Fannin County which has a 2011 census of 33,358 representing 1% increase from the previous year. (1a) Including the approximate 180 patients in Fannin County, TCC has four primary clinics providing treatment to over 1,200 adults, children, and families who range in age from birth to death. Less than 1% of TCC's patients have private insurance and 38-40% have Medicaid, and 88% of children and 81.34% of adult patients are at or below the federal poverty level. TCC provides an average of 10,226 face to face patient contacts per month. (1b)

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

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

Target Population: Patients needing intensive out-patient substance abuse treatment comprise the target population for Project 084434201.1.2.

Category 1 or 2 Expected Patient Impact/Benefits: TCC expects to establish one new substance abuse treatment site and provide intensive out-patient SA treatment to 5 patients in DY 3, 10 in DY 4 and 15 in DY 5 for a total patient impact of 30 RHP 1 residents benefitting from these services for a community value of $166,746.00. In addition, TCC will provide LCDC supervision to at least 3 interns. The same Medicaid and poverty level percentages will apply to all patients receiving services through this project for a significant regional impact.

Category 3 Outcomes: The Category 3 Quality Improvement Project is IT-10.1, Quality of Life. Expanding substance abuse treatment options will positively impact patients' ability to function, thus improving outcomes to the community through **reduced** emergency department visits, psychiatric hospitalizations and preventable admits and re-admits, adjudications and incarcerations. The

valuation methodologies still does not account for additional health care savings to the community related to the additional treatment providers that will eventually serve the community.

Project Narrative

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

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

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

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

TCC's own crisis service data reveals that, of the average 124 face to face crisis encounters each month, 57% report substance abuse as a precipitating cause of their crisis event. (20) However, substance abuse being a significant cause of crisis events is a nation-wide problem according to a July 11, 2012 SAMHSA Release the DAWN Report which is intended to help agencies to implement policies

that will provide "prevention, intervention and treatment of substance abuse… and 47% of the ER visits they reviewed were due to drug abuse or misuse" which is a 115 % increase in just six years. (21) Referral sources in the three-county service area include two out-patient programs and 1 faith-based support-group program, but this is still "out of county" for individuals in Fannin County. When these treatment programs are at capacity and they often have waiting lists of several months, patients must be referred out of county. This area is underserved by licensed providers overall (CN.2).

Our own experience as the Local Mental Health Authority has been frustration at the lack of substance abuse treatment options within the tri-county service area (CN.2). SAMHSA reports that: "By 2020, mental & substance use disorders (M/SUDs) will surpass all physical diseases as a major cause of disability worldwide." (23) With state-funded substance abuse reductions having occurred in the past few years, patients have to be sent out of area, separated from families and support, to receive treatment when the few existing resource options are at capacity, which is all of the time. Providing substance abuse treatment is not a new initiative for TCC but establishing a separate, licensed substance abuse treatment program that also provides LCDC Internship opportunities is a new initiative plus it significantly enhances the current service effort. TCC is dedicated to achieving these desired health outcomes, to improving efficiency and reducing costs; therefore, enhancing substance abuse treatment and provider licensing internship programs will improve outcomes and making a positive impact on the lives and well-being of the populations served.

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

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

Expanding substance abuse treatment services and developing an internship program for additional LCDC providers will definitely impact the functional status and overall quality of life of individuals serviced through these projects. Laudet (2011) writes in his article *The case for Considering Quality of Life in Addiction Research and Clinical Practice,* that: "Substance use disorders (SUDs) are characterized as 'maladaptive patterns of substance use leading to clinically severe impairment or distress' potentially affecting physical or psychological functioning; personal safety; social relations,

roles, and obligations; work; and other areas (American Psychiatric Association, 1994) … SUD is a chronic condition for most affected individuals, and QOL [Quality of Life] improvement is a particularly important goal in treating conditions that cannot be cured." (24) As such, having the Quality of Life/Functional Status Outcome Measure to determine impact to patient care. Assessing patient access and outcomes is relevant to contributing to the overall goals identified in Category 3.

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

Relationship to Other Performing Providers' Projects in the RHP: The primary relationship that the Expansion of Substance Abuse Project will have to the other Projects in RHP 1 is one of collaboration, sharing of data and information, and referrals as appropriate. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve specific counties, but no individuals who reside in other counties; therefore, collaborating on projects will likely occur over time as regional meetings occur. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 1 in order to enhance best practice models is a definite TCC goal. It is acknowledged that Lakes Regional MHMR Center is the contracted LMHA providing DSHS substance abuse treatment in Fannin County, however, and the TCC expansion is in no way intended to replace that provider source for the area. The community need (CN.2) for additional substance abuse and behavioral health providers in Fannin County allows for both LMHA's to provide substance abuse treatment without duplicating services or even meeting the need fully.

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

Project Valuation: The value of this project expands the scope of TCC's services to a population identified as a primary contributor to community costs. RHP needs assessments (CN.2, CN.4, CN.5, CN.6) indicate that there is a recognized need for additional outpatient treatment services for persons with chemical dependency problems.

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

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A search of the scientific literature identified the following two studies that support this methodology. The first study we identified looking at telemedicine and mental health was conducted by Pyne (2010) which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. (9c) Another study by Hollinghurst et al (2010) examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALy gain for intervention was 0.034. (9d) The average of the two estimated QALYs is 0.0245. Then, two additional studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. (9e) Drummond et al, (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. (9f) The average of these two values is

0.11135. Using this methodology, it is deduced that TCC will establish one new substance abuse treatment site and provide intensive out-patient SA treatment to 5 patients in DY 3, 10 in DY 4 and 15 in DY 5 for a total patient impact of 30 RHP 1 residents benefitting from these services for a community value of $166,746.00.

The value of the project will increase over time, but it is expected that there will be an exponentially greater value brought to community by bringing earlier resolution to challenges for individuals that currently cost our communities a great deal through emergency room admissions and re-admissions, and to the criminal justice systems for adjudication and detention. The value of the project will be greatly enhanced by the use of TCC's telecommunication infrastructure, which will allow rapid access to existing electronic information, telecommunication with related stakeholders, and videoconference counseling and psychiatric services. TCC expects to continue expansion of both the treatment and counselor training program, and will look to other local sources of support and third-party payment systems for continuation and expansion.

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1- Identify licenses, equipment requirements and other components needed to implement and operate options selected. P.2.1 Metric- Develop a project plan and timeline detailing the operational needs, training materials, equipment and components— Baseline/Goal: -Research existing regulations pertaining to the licensure requirements of substance abuse clinics to determine what requirements must be met. -When required, obtain licenses and operational permits as required by	Milestone 3- P-4- Hire and train 1 Certified & experienced licensed counselor/program coordinator to manage and oversee Substance Abuse Treatment & Internship Program and 1 clerical staff to support program administration. P-4.1 Metric - Number of Staff secured and trained Baseline: Zero staff secured and trained Goal: Both positions filled & staff trained in respective duties Data Source: Project records, HR records and training records Milestone 3 Estimated Incentive Payment: $13,847.33 Milestone 4-P-6 – Establish new behavioral health service site in community-based setting in underserved areas P-6.1 Metric –Increased number of new community-based sites where behavioral health services	Milestone 6-I.11- Increase utilization of substance abuse community behavioral healthcare program. I-11.1 Metric– Increased number of patients and interns receiving TCC substance abuse community behavioral healthcare services. Baseline: Zero patients receiving services; zero interns receiving supervision Goal: 10 patients receiving substance abuse services after access expansion; 2 interns receiving supervision after expansion Data Source: Claims data and encounter data from behavioral health site; internship verification reports Milestone 6 Estimated Incentive Payment: $22,219.50 Milestone 7- P-10- Participate in	Milestone 8-I.11- Increase utilization of substance abuse community behavioral healthcare program I-11.1 Metric– Increased number of patients and interns receiving TCC substance abuse community behavioral healthcare services. Baseline: Zero patients receiving services; zero interns receiving supervision Goal: 15 patients receiving substance abuse services after access expansion; 3 interns receiving supervision after expansion Data Source: Claims data and encounter data from behavioral health site; internship verification reports Milestone 8 Estimated Incentive Payment: $21,468.50 Milestone 9- P-10- Participate in

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
the state, county or city in which the clinic will operate. a. Data Source: Project Plan Milestone 1 Estimated Incentive Payment: $18,914.00 Milestone 2-P-3- Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for the substance abuse and internship programs) P-3.1 Metric- Manual detailing administrative protocols and clinical guidelines are in place Baseline/Goal: Manual written and in place. a. Data Source:	are delivered and number of patients being served. a. Number of patients served at these new community-based sites: Baseline: No community-based site and Zero patients served Goal: 1 new community-based site and 5 Patients being served Milestone 4 Estimated Incentive Payment: $13,847.33 Milestone 5- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to	face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No meetings attended Goal: Two meetings attended by TCC staff Data Source: Documentation of semiannual meetings including meeting agendas, slides from	face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No meetings attended Goal: Two meetings attended by TCC staff Data Source: Documentation of semiannual meetings attended including meeting agendas, slides

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Administrative protocols; Clinical guidelines Estimated Milestone 2 Incentive Payment *(maximum amount):* $18,914.00	implementing these improvements. P-10.1 Metric: – Participate in semi-annual face- to-face meetings or seminars organized by the RHP: Baseline: No meetings attended Goal: Two meetings attended by TCC staff Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-10.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting.		presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-10.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives established Goal: Initiatives established, and being implemented documented Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and	from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-10.2 Metric -- Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives established Goal: Initiatives established, and being implemented documented Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Baseline: No initiatives established Goal: Initiatives established, documented and being implemented. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 5 Estimated Incentive Payment *(maximum amount):*		documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 7 Estimated Incentive Payment *(maximum amount):* $22,219.50	documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 9 Estimated Incentive Payment *(maximum amount):* $21,468.50

084434201.1.2	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.2	IT-10.1	Quality of Life/Functional Status
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	$13,847.34		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $37,828.00	Year 3 Estimated Milestone Bundle Amount: $41,542.00	Year 4 Estimated Milestone Bundle Amount: $44,439.00	Year 5 Estimated Milestone Bundle Amount: $42,937.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $166,746.00			

Project Option: 1.12.2 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas.
Unique Project ID Number: 084434201.1.3 (Pass 1)
Performing Provider Name/TPI: Texoma Community Center 084434201.1.3

Project Abstract

Provider: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC has a clinic in Fannin County which has a 2011 census of 33,358 representing 1% increase from the previous year. (1a) Including the approximate 180 patients in Fannin County, TCC has four primary clinics providing treatment to over 1,200 adults, children, and families who range in age from birth to death. Less than 1% of TCC's patients have private insurance and 38-40% have Medicaid, and 88% of children and 81.34% of adult patients are at or below the federal poverty level. TCC provides an average of 10,226 face to face patient contacts per month. (1b)

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

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

Target Population: Patients who need therapeutic intervention in the form of counseling, specifically for Medicaid and/or low-income patients, are the target population for this project. TCC clinicians are credentialed in providing evidenced-based therapy appropriate to the presenting problems.

Category 1 or 2 Expected Patient Benefits: Patient benefits will include one additional resource site for Medicaid-funded or indigent counseling. Using Katon's (2012) research methodology for economic impact, as he examined collaborative care interventions for multi-symptom patients, this project's valuation is $265,192.00. (9g) By DY 3 TCC will serve 10 new counseling patients, 15 in DY 4 and 25 in DY 5. These patients would not have access to counseling due to a lack of funding.

Category 3 Outcomes: The Category 3 outcome benefit as valued by Katon's (2012) methodology, as he examined collaborative care interventions for multi-symptom patients including depression, diabetes, and coronary heart disease, this project will benefit an additional 23 individuals from Fannin County over the baseline, for a value of $391,951.00 to the community by DY 5. However, exact improvement targets will be determined in DY 2 as baseline data is gathered. Considering TCC's "track

record" of program efficiency, it is very realistic to expect the outcomes over the four years will be reached and exceeded.

Project Narrative

Project Description: Texoma Community Center (TCC) will expand counseling services to additional behavioral health patients by providing additional licensed staff designated to provide evidenced-based therapeutic counseling to those who do not meet criteria for TCC's DSHS-funded services as well as provide the office space, furniture, telementalhealth and other equipment, supplies and clerical support for efficient business operations. The TCC service area is deemed underserved in behavioral health services and the community has a need for counseling options (CN.2, CN.4). Expanding TCC's counseling services by hiring a minimum of two (2) licensed clinicians to serve non-target population patients. Those clinicians will provide evidenced-based counseling interventions to unfunded and low income patients in this underserved area which will allow access to behavioral health treatment (CN.2). The current DSHS diagnostic criteria are very restrictive and regimented for who can be served with state funds. TCC's own internal data sources show that in 2011 and to-date in 2012, 618 individuals sought mental health treatment, but were denied services because they did not have a "target population" diagnosis. The majority of those 618 individuals had a valid mental health or emotional disturbance issue and could have benefitted from counseling services. (25) Because these individuals had no health coverage, there were no counseling resources available except for support groups primarily based in the Dallas area. There are area counselors, but they all require a funding source.

The ability to broaden the scope of counseling treatment and opening up the restrictive diagnostic criteria will allow staff clinicians to provide a much needed service, as evidenced by the 618 individuals a year seeking TCC services who have to be denied due exclusively to diagnostic criteria. While some of the individuals who were denied services might not require counseling, the majority definitely requested counseling and could benefit from such a service. Internal clinical data shows that many of those individuals assessed suffered from Post-Traumatic Stress Disorder and/or depressive disorders with Global Assessment of Functioning Scores (26) above 50, thus ruling them out of services, or they had anxiety disorders, all of which respond well to appropriate evidenced-based therapy. A significant number of patients accessing emergency rooms and/or psychiatric hospitals suffer from one of these disorders. Providing expanded out-patient services to these individuals and using the best evidenced-based treatment modalities for the identified diagnosis will improve treatment outcomes, reduce potentially preventable hospital admits and reduce potentially preventable and very costly hospital readmissions. Expanding services to non-DSHS target individuals will address a deficit in this underserved area for individuals needing therapeutic counseling services but lacking a funding source (CN.2).

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

Starting Point/Baseline: Currently TCC provides counseling services to individuals diagnosed with one of the DSHS state-mandated target diagnoses of schizophrenia, bipolar disorder or major depressive disorder in three primary clinic sites. While treating these disorders is a priority, individuals who do

not have one of these three diagnoses are not allowed treatment with TCC. The majority of our crisis events involve individuals who do NOT have a co-occurring severe and persistent mental illness but still need therapeutic intervention and could benefit from counseling. The baseline for treating individuals **without** a target diagnosis of severe and persistent mental illness in a NEW counseling site without restriction of diagnosis is currently zero (0) and beginning in DY 3 this will be the baseline.

Rationale: Overall, Texas healthcare is grossly underfunded. A lack of insurance by many Texans causes them to use the emergency rooms as a primary care clinic. Texas has 1,247,300 children and 4,886,100 adults who are uninsured.(27) All of the TCC projects, including expanded counseling access, are designed to help solve several identified needs in the region by increasing the number of patients served and preventing unnecessary emergency room visits. (CN.2, CN.4, CN.5). TCC was approved for the National Health Service Corp's federal loan repayment program for qualified staff specifically due to NHSC statistics showing that the three county service area was significantly underserved by all licensed providers, including counselors and psychiatrists. Expanding therapeutic services reduces these shortages. (1c) (CN.2) While counseling is not a new initiative for TCC, expanding those services beyond the DSHS target population will be new. Being able to expand the diagnostic criteria will also be a new and exciting initiative for TCC.

As previously stated, especially during the past six years, Texoma Community Center has successfully demonstrated clinical and financial responsibility while improving and enhancing service provision. Providing an additional counseling treatment site and employing additional clinicians to provide needed services (CN.2), in addition to ensuring the support, oversight and guidance necessary to meet and exceed performance measures, will expand and enhance the quantity and quality of services to patients. There is a direct correlation between the intensified and improved out-patient services provided to "high-utilizer" patients seeking care in emergency rooms and local hospitals, including psychiatric hospitals, and the reduction of hospitalizations and incarcerations overall which supports and reinforces regional goals. TCC tracked hospitalizations for the "high utilizer" psychosocial rehabilitation patients and an outcome was that increased services appeared to reduce crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (29) The ability to provide intensive oversight of services while demanding highly ethical provider behavior, along with our willingness to collaborate with other providers and stakeholders, has helped produce positive outcomes over time. TCC is dedicated to achieving these desired health outcomes, to improving efficiency and reducing costs. Those measures have a positive impact on the lives and well-being of the populations served.

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

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

evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

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

Treatment efficacy can be determined by assessing the functioning and quality of life outcomes of individual patients, which in turn, supports Category 3 goals. Clark & Kirisci (1996) report in a study of adolescents suffering from affective disorders, including PTSD, that: PTSD showed significant adverse effects on Psychological, physical, and social functioning. Major depression showed a similar pattern. In contrast, alcohol use disorders primarily affected role functioning. While PTSD, major depression, and alcohol use disorders all adversely influenced adolescent QOL [quality of life] ….”(30) In addition, Zatrick, MD ((1997) stated: “The prevalence of PTSD also increased consistently with the number of self-reported chronic diseases (t2). Only 9,6%of subjects reporting no chronic conditions had PTSD, whereas 31.9% of subjects with four or more conditions had PTSD . . . . Subjects with PTSD demonstrated consistently higher risks of functional impairment; for five of the six outcomes the risks of impaired functioning . . . exceeded 20% (t3).” (31)

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

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

Relationship to Other Performing Providers’ Projects in the RHP: The primary relationship that the Expansion of Counseling Services Project will have to the other Projects in RHP 1 is one of collaboration, sharing of data and information, and referrals as appropriate. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve specific counties, but no individuals who reside in other counties; therefore, collaborating on projects

will likely occur over time as regional meetings occur. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers in RHP 1 in order to enhance best practice models is a definite TCC goal. There are several projects where telehealth is included in implementation, as it is with TCC, which will open up the possibility of communicating directly with these specific providers through telecommunications. Also, Lakes Regional MHMR Center also plans to expand counseling services and cross-referrals and collaboration will be sought. The extensive need (CN.2) for additional behavioral health providers allows for both LMHA's to expand counseling services outside of their respective county diagnostic restrictions without duplicating services or even meeting the need fully.

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

Project Valuation: The value of this project expands the scope of TCC's services to a population identified as a primary contributor to community costs. RHP needs assessments (CN.2, CN.4, CN.5) indicate that there is a recognized need for additional outpatient treatment services for persons with chemical dependency problems. The individuals to be served by this new counseling program are those who create the greatest distress in the community by being found in crisis in emergency rooms. This expansion of TCC services will create increased community value by providing additional treatment to those who have no funding source and thus affording the opportunity for more individuals to become stable with increased treatment options. The cost for the project will be greatly outweighed by the evidence-based recognition of a multiplier impact on cost reduction as such interventions and treatment reduce emergency room and hospital re-admissions, lower the prospect of future encounters with the medical and criminal justice systems, and help individuals into recovery where they can be contributing members of their community.
Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the

program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The researchers also looked at cost savings in valuing this program. (9a)

To support this valuation methodology, research was reviewed. A study by Jones et al. (2003) showed that participants receiving Critical Care Intervention had 58 fewer homeless nights compared with standard treatment participants. A night of homelessness was valued at $152 using a societal perspective which results in a value gain of $8,816 per participant. (9j) Chronic alcohol abusers tend to be homeless at higher rates than the general population. Then Larimer, et al. (2009) showed that this type of program for chronically homeless individuals with severe alcohol problems showed a cost-offset of $2,449 per month per individual. (9K) Then finally using Katon's (2012) methodology (9g), it was determined that by DY 3 TCC will serve 10 new counseling patients, 15 in DY 4 and 25 in DY 5. The total valuation of this project is $265,192.00 and the patient impact is that at least 50 RHP 1 residents would benefit. These patients would not have access to counseling due to a lack of funding.

The cost of the project will increase over time, but it is expected that there will be an exponentially greater value brought to community by bringing earlier resolution to challenges for individuals that currently cost our communities a great deal through emergency room admissions and re-admissions, and to the criminal justice systems for adjudication and detention. The value of the project will be enhanced by the use of TCC's telecommunication infrastructure, which will allow rapid access to existing electronic information, telecommunication with related stakeholders, and videoconference counseling and psychiatric services. TCC expects to continue expansion of both counseling program and will look to other local sources of support and third-party payment systems for continuation and expansion.

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			*084434201*
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1-P.2 -- Identify licenses, equipment requirements and other components needed to implement and operate options selected. P.2.1-Metric: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components— Research existing regulations pertaining to the licensure requirements of clinicians to determine what requirements must be met. -When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate. Note: This will not be a mobile clinic so rest of protocol does not apply. Baseline: No plan	Milestone 3- P-4- Hire and train 2 licensed clinicians to provide counseling services in newly established counseling program. P-4.1-Metric : Number of Staff secured and trained Baseline: Zero staff secured and trained Goal: 2 staff secured and trained in respective positions Data Source: Project records, HR records and training records Milestone 3 Estimated Incentive Payment: $22,023.00 Milestone 4-P-6 – Establish behavioral health services in new community-based setting in underserved area. P-6.1-Metric : Number of patients receiving counseling services in new community-based setting Baseline: 3 sites/zero patients Goal: 4 sites/ 10 patients served at new site	Milestone 6-I.11- Increase utilization of community behavioral healthcare I-11.1 Metric– Increased number of patients utilizing TCC counseling community behavioral healthcare services. Baseline: zero patients receiving counseling services at new site Numerator: Number receiving community behavioral healthcare services from clinic after expansion Denominator: Number of people receiving community behavioral health services Goal: 15 patients receiving counseling services at new community behavioral health clinic after access expansion Data Source: Claims data and encounter data from behavioral health site; internship verification reports	Milestone 8-I.11- Increase utilization of counseling behavioral healthcare program by 6 patients over baseline of # served in program in DY4. I-11.1 Metric– Number of patients receiving TCC counseling community behavioral healthcare services. Baseline: zero patients receiving counseling services at new site Numerator: Number receiving community behavioral healthcare services from clinic after expansion Denominator: Number of people receiving community behavioral health services Goal: 25 patients receiving counseling services at new community behavioral health clinic after access expansion Milestone 8 Estimated Incentive Payment: $ 34,143.00

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			*084434201*
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
operational Goal: Project plan in place and operational needs met. Data Source: Project Plan documentation Milestone 1 Estimated Incentive Payment: $ 30,081.00 Milestone 2-P-3- Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for the counseling project). Metric-P-3.1 – Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline: No operations manual in place Goal: Operations manual in place and	Data Source: Site plans/leases and Encounter Data Milestone 4 Estimated Incentive Payment: $ 22,023.00 Milestone 5- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1-Metric: Participate in semi-annual face- to-face	Milestone 6 Estimated Incentive Payment: $ 35,338.00 Milestone 7- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1-Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP.	Milestone 9- P-10- Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. P-10.1 Metric: Participate in semi-annual face- to-face meetings or seminars organized by the RHP. Baseline: No meetings attended by TCC staff Goal: Two meetings attended

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.
Texoma Community Center			*084434201*
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
protocols/guidelines being followed Data Source: Administrative protocols; Clinical guidelines Milestone 2 Estimated Incentive Payment: $30,081.00 Estimated Incentive Payment *(maximum amount):* $60,162.00	meetings or seminars organized by the RHP Baseline: No meetings attended by TCC staff Goal: Two meetings attended by TCC staff Data Source: Documentation of semiannual meetings including meeting agenda, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Metric P-10.2--Implement "raise the floor" improvement initiatives established at the semiannual meeting.	Baseline: No meetings attended by TCC staff Goal: Two meetings attended by TCC staff Data Source: Documentation of semiannual meetings including meeting agenda, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-10.2 Metric: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives identified	by TCC staff Data Source: Documentation of semiannual meetings including meeting agenda, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. P-10.2- Metric: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives identified Goal: Initiatives identified and being implemented Data Source: Documentation of "raise the floor" improvement

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center				*084434201*
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Baseline: No initiatives identified Goal: Initiatives identified and being implemented Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 5 Estimated Incentive Payment *(maximum amount):*		Goal: Initiatives identified and being implemented Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 7 Estimated Incentive Payment *(maximum amount):* $ 35,338.00	initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented "raise the floor" improvement imitative after the semiannual meeting. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers. Milestone 9 Estimated Incentive Payment *(maximum amount):* $ 34,143.00

084434201.1.3	Project Option:1.12.2	N/A	Enhance service availability (i.e. hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.	
Texoma Community Center				*084434201*
Related Category 3 Outcome Measure(s): OD-10	084434201.3.3	IT 10.1	Quality of Life/Functional Status	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	$22,022.00			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $60,162.00	Year 3 Estimated Milestone Bundle Amount: $66,068.00		Year 4 Estimated Milestone Bundle Amount: $ 70,676.00	Year 5 Estimated Milestone Bundle Amount: $68,286.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 265,192.00				

Project Option: 1.10.3 – Enhance improvement capacity within systems.
Unique Project ID Number: 084434201.1.4 (Pass 1)
Performing Provider Name/TPI: Texoma Community Center 084434201

Project Abstract

Provider: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties (Cooke, Grayson and Fannin) in North Central Texas covering 2,698.4 square miles. TCC has a clinic in Fannin County which has a 2011 census of 33,358 representing 1% increase from the previous year. (1a) Including the approximate 180 patients in Fannin County, TCC has four primary clinics providing an average of 10,226 face to face treatment encounters to over 1,200 adults, children, and families who range in age from birth to death. Less than 1% of TCC's patients have private insurance and 38 % have Medicaid, and 88% of children and 81.34% of adult patients are at or below the federal poverty level. (1b)

Interventions: This project expands quality improvement capacity through people, processes and technology in order to conduct, report, drive and measure quality improvement. The interventions will increase data reports in order to expand the patient population and services by improving efficiencies and solving key challenges through focused and frequent (weekly) evaluation of intervention barriers and progress in service areas.

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

Target Population: The target population benefit for Project 084434201.3 is spread across the entire existing and prospective TCC patient population which is approximately 220 current patients in RHP 1 and approximately 250 face-face crisis encounters annually. (1b)TCC expects that each service area will have appropriate implementation, improved efficiency, and clinically sound application of services ensured through continuous quality improvement processes.

Category 1 Expected Patient Benefit: TCC reviews a twelve QI reports weekly or monthly. The expectation is to track improvement trends in order to impact quality patient outcomes. To do this QI reports will be increased by 10% in DY3, 15% in DY 4, and 20% in DY 5. While the valuation for this project is calculated to be $80,762.00 with a patient impact of 50 additional patients served, it is helpful, in assessing impact, to consider additional methodologies. Studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and Lehamn (1999), showed that, based on an enhancement of capacity at an average savings of $13,856 per person, the region could expect an impact health care savings $192,800.00. (9i, 9k, 9l, 9m)

Category 3 Outcomes: The related Category 3 Project is IT-9.2, ED Appropriate utilization to Reduce Emergency Department (ED) visits for target conditions. TCC expects to reduce ED visits for target populations by DY5. Exact targets will be determined in DY 2 because this is a new service and precise baseline numbers are not available until the first year of the project.

Project Option: 1.10.3 Enhance improvement capacity within systems

Required core project components**:**

(a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture;

(b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

Project Narrative

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

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

TCC commits to meet the required core components by developing initiatives based on process improvement methodologies appropriate to rapid communication, integrated system workflows, providing data to providers and patients, eliminating waste, enhancing provider performance and improving patient-centered care. TCC will: (a) provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture and will (b) develop an employee suggestion system assesses project impact on work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. Further, TCC will:

(1) develop protocols and tools designed to identify project impacts;
(2) understand what "lessons have been learned;"
(3) expand the patient population and services;
(4) identify and solve key challenges to successful expansion; and
(5) identify special considerations for target populations.

TCC will continue to address issues of safety, quality, and efficiency through continuous quality improvement in order to contribute to the regional (RHP 1) overarching goals to "(1) improve quality of care and patient satisfaction, (2) improve the health of populations, (3) reduce the cost of health care, and (4) improve access to health care services—physical, mental, and behavioral health." (RHP 1 Anchor Plan) Texoma Community Center recognizes that project success requires essential quality improvement elements such as being open to change, fostering patient safety, effective problem solving, soliciting stakeholder feedback and engaging in continuous monitoring of performance in order to report findings and use those finding to direct and improve services.

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

Starting Point/Baseline: The baseline begins with no office dedicated full time to quality improvement and reporting capacities, no identified training programs, and no organized set of principles, strategies, tools or reporting capabilities based on evidenced-based processes. The milestone baseline consists of the twelve QI reports that are currently reviewed beginning with DY 2. There has not been a concerted effort to develop evidenced-based strategies utilizing specific tools or a full time position just for quality improvement and reporting capacities.

Rationale: TCC is starting this Quality Improvement Project with an established "track record" in stabilizing high utilizer patients in the area's medical community. The following "look back" at what TCC has accomplished during the past six years is only to connect the accomplishments to the RHP 1 regional goals and the health care transformation goals because they exemplify what can be accomplished if expanded to a regional level. Since 2006, TCC's management team has made comprehensive changes that have been an on-going process of consistent communication with supervisory and soliciting stakeholder feedback necessary to identify problems along the way. The management team has been aggressive in finding creative solutions that are both clinically sound with "evidenced-based" treatment, and financially sound with frequent oversight and open disclosure. These efforts were successful to differing degrees in our three-county service area. Overall, the changes and collaborations had a significant impact on improving the Center's financial stability and contributed to positive are outcomes. The following internal data exemplify goals that are completely consistent with current regional transformation goals. TCC intends to continue this improvement model by creating a specific department dedicated to enhance the reporting capacity, continue performance improvement and expand rapid solutions to inefficiencies, waste, and barriers.

The first major change for TCC occurred with the Assertive Community Treatment Program (ACT) for those with severe and persistent mental illness. These intensive out-patient services were ramped up with specific goals to reduce hospitalization costs. The result was a reduction of average psychiatric hospitalizations for this discreet population over a four-year time period from 1.8% in 2007, 1.6% in 2008, .23% in 2009, 0% in 2010. Hospitalization rates

for these individuals in 2011 were at .56% due to adding new patients to this caseload who required initial stabilization. (2) Also, other "high utilizer" patients are in TCC's out-patient psychosocial rehabilitation program. This group showed a reduction in crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, to 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (3) The following table also exemplifies how TCC already has expertise in reducing costs and TCC is poised to continue improving on these existing accomplishments:

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

(4)

These initiatives and cost reductions show the broad improvements made by TCC between the years 2006 to present, which were accomplished largely due to a weekly oversight committee that was dedicated to identifying weaknesses, developing strengths and overseeing the changes that were essential for meeting DSHS contract measures and program requirements across all service areas. Strong oversight of rehab services provides the support and guidance necessary to meet and exceed performance measures, while increasing quality of services to patients. The targeted changes led to dramatic reductions in both local hospitalization costs and reduced hospitalizations for funded Center patients as well. Medication costs were reduced by addressing prescribing practices with psychiatrists and developing a medication formulary and aggressively pursuing Patient Assistance Program medications, all while still ensuring patients were stabilized. This improvement trend has continued into 2012. There appears to be a direct link between the intensified and improved services provided to "high-utilizer" patients and the reduction of hospitalizations. Additionally,

utilization of the Department of State Health Services' State Hospital allocation was reduced from 140% overuse in 2006 to its current rate of 60% of the DSHS allocation (5).

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

As demonstrated above, enhancing the quality improvement and data management strategies is not a "new initiative" for TCC but this project will "significantly enhance" the improvement process that led to the outlined changes. This enhancement is essential to continue the endeavors, support the regional goals, and address the identified regional needs (CN.1, CN.2, CN.4, CN.5, and CN.6). TCC intends to accomplish additional improvements by adopting more specific, evidenced-based process-improvement techniques that will continue to identify inefficiencies, inadequate care and preventable errors. TCC recognizes that quality improvement is a dynamic process that requires a multitude of tools that address multiple areas of change in over-lapping systems, and an evidence-based, dedicated approach to improving these systems is essential to meeting improvement outcomes while making a positive impact on the lives and well-being of the populations served.

Related Category 3 Outcome Measure(s): OD-9 Right Care, Right Setting

OD-9 Right Care, Right Setting

IT-9.2 ED Appropriate utilization (standalone measure)

a. Reduce Emergency Department visits for target conditions
   Behavioral Health//substance Abuse
b. Data Base: Center Encounter Data and Center Clinical Data
c. Rationale/Evidence: The Right Care, Right Setting Outcome Domain

TCC selected this measure in order assess service delivery impact specific to a targetpopulations—individuals with mental illness, emotional disturbance and substance abuse issues who live within the region. TCC recognizes that developing a well-organized and impactful quality improvement system is vital to actually impacting patient outcomes, to improve patient functioning and thus to intentionally reduce potentially preventable hospitalizations in the area of behavioral health and substance abuse. It is recognized that effective quality improvement requires relentless focus on the patient outcomes.

The Quality Improvement Project is especially relevant to the Category 3 emphasis on outcome measure assessment. Directing attention and tracking the data for related hospitalizations will provide a more complete picture of the intervention impact on the behavioral health status of Fannin counties' low-income population. In fact, Fannin County's health ranking from the US Department of Health & Human Services' *"2012 County Health Rankings"* shows that Fannin County residents have "5.3 poor mental health days" compared to the Texas average of "3.3 poor health days" and even more significant is that Fannin residents have "7.3 poor physical health days" (CN.1) compared to the Texas average of "3.6 poor health days;" furthermore, Fannin County shows to have identified "83 preventable hospital stays, compared to the Texas average of 73 hospital stays." (7) Individuals who are in poor mental or physical health are the very individuals who seek emergency treatment, especially if they lack health insurance because unfunded patients tend to use the ED as a primary care clinic for minor medical issues. The Quality Improvement Project will enhance TCC's capacity to accomplish the project and regional goals.

Clearly, with a dedicated QI program, TCC will be able to focus on tracking, assessing and improving the ED use for Fannin County residents, and help accomplish the desired Category 3 goal for this health-professional underserved area (CN.2, CN.4, CN.5).

Relationship to other Projects: Project 084434201.1.4 is central to all of the other projects submitted by TCC. Implementation of this project will drive data oversight, coordination and facilitate outcome success of ALL other TCC projects (084434201.1.1, 084434201.1.2, 084434201.1.3, 084434201.2.1). This project is a vital element in assuring that milestones and metrics are achieved across the other projects. The data and "lessons learned" will be shared in regional collaborations with other providers in order to support the overall regional goals.

Relationship to Other Performing Providers' Projects in the RHP: The primary relationship that the QI Project will have to the other Projects in RHP 1 is one of collaboration. Local Mental Health Authorities are unique in that they are designated by The Department of State Health Services to serve specific counties, but no individuals who reside in other counties; therefore, collaborating on projects will enhance expansion to broader patient bases. There are no specific TCC projects that are combined in implementation with other providers in the region. However, Lakes Regional MHMR Center plans to expand behavioral health care within this region and data sharing and collaboration will occur. Also, the Andrews Center will be expanding care and collaboration will also occur. The need (CN.2) for additional behavioral health providers allows for all RHP 1 LMHA's to expand behavioral health services outside of their respective county restrictions without duplicating services or even meeting the need fully.

Plan for Learning Collaborative: The RHP 1 Anchor will develop and convene the Learning Collaborative opportunities with input from the regional providers. This opportunity will facilitate success throughout the region. TCC does plan to participate in the learning collaborative meetings in order to share knowledge, experience and outcomes across the region for quality improvement purposes. In fact, the Quality Improvement Project is designed specifically to create a position within our Center that focuses on data and experience sharing

and to bring that information back to the management table to help direct TCC's future growth toward even more sound, cost-effective, evidence-based practices.

Project Valuation: TCC's establishment of a QI Department is consistent with the U.S. Department of Health and Human Services' objective to: "Reduce the growth of healthcare costs while promoting high-value effective care. "(8) TCC recognize that: "From the perspective of a service provider or program manager, quality ensures effectiveness and efficiency. From the perspective of the policy maker, quality is the key to improving the mental health population, ensuring value for money expended and accountability." (9) Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. For example, Dewa et al. (2009) found that collaborative care saved $503 per patient in disability benefits. (9h) A cost-utility analysis by Holtgrave, (2012) was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is $62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life. (9b) Using Dewa and Holtgrave methodologies, the valuation for this project is calculated to be $80,762.00 with a patient impact of 50 additional patients served. But it is helpful, in assessing impact, to consider additional methodologies. Studies by Clark, et., al. (1998), Essock, et. al. (1998), Latimer (2005) and Lehamn (1999), showed that, based on an enhancement of capacity at an average cost savings of $13,856 per person, RHP 1 can expect an impact health care savings valuation of $192,800.00.(9i, 9k, 9l, 9m).

084434201.1.4	PROJECT OPTION: 1.10.3	PROJECT COMPONENTS: 1.10.3.A.*B*	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.4	IT-9.2	ED Appropriate Utilization (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 – P-6: Hire/train 2 quality improvement staff who will be trained in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics for reporting purposes (e.g., to measure improvement and trends). P-6.1 Metric: Hire and train 2 staff in quality and efficiency improvement principles Baseline: zero Goal: 2 trained staff Data Source: HR records, Training Rosters and Sign-in Sheets or Certificates of Completion Milestone 1 Estimated Incentive Payment: $ 18,322.00	Milestone 2 I-7: Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports I-7.1 Metric : Increase the number of reports generated through these quality improvement data systems Baseline: Twelve (12) Numerator: Number of reports generated Goal: 10% improvement (1 new report) being used to improve quality outcomes Data Source: Quality Improvement Data System Rationale/Evidence: It is important to accurately collect data on quality outcomes and patient experience as well as		Milestone 3 – I-7: Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports I-7.1Metric: Increase the number of reports generated through these quality improvement data systems Baseline: Twelve (12) Numerator: Number of reports generated Goal: 15% improvement (2 new reports)) being used to improve quality outcomes Data Source: Quality Improvement Data System Rationale/Evidence: It is important to accurately collect	Milestone 4 – I-7: Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports I-7.1 Metric: Increase the number of reports generated through these quality improvement data systems Baseline: Twelve (12) Numerator: Number of reports generated Goal: 20% improvement (3 new reports)) being used to improve quality outcomes Data Source: Quality Improvement Data System Rationale/Evidence: It is important to accurately collect

084434201.1.4	PROJECT OPTION: 1.10.3	PROJECT COMPONENTS: 1.10.3.A.*B*	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.4	IT-9.2	ED Appropriate Utilization (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	present the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions. These reports should be generated monthly, if not more frequently, to measure the impact of improvement activities on the improvement goals/targets. Milestone 2 Estimated Incentive Payment: $ 20,120.00		data on quality outcomes and patient experience as well as present the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions. These reports should be generated monthly, if not more frequently, to measure the impact of improvement activities on the improvement goals/targets. Milestone 3 Estimated Incentive Payment: $21,524.00	data on quality outcomes and patient experience as well as present the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions. These reports should be generated monthly, if not more frequently, to measure the impact of improvement activities on the improvement goals/targets. Milestone 4 Estimated Incentive Payment: $20,796.00
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts	Year 3 Estimated Milestone Bundle Amount: $20,120.00		Year 4 Estimated Milestone Bundle Amount: $21,524.00	Year 5 Estimated Milestone Bundle Amount: $20,796.00

084434201.1.4	PROJECT OPTION: 1.10.3	PROJECT COMPONENTS: 1.10.3.A.*B*	ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.4	IT-9.2	ED Appropriate Utilization (Standalone measure)	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
from each milestone): $18,322.00				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $80,762.00				

Project Option: 1.1.2 Expand Primary Care Capacity
Project Identifier: 094108002.1.1 (Pass 1)
Performing Provider Name/TPI: Mother Frances Hospital 094108002

Project Abstract

Provider Description: Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care is close to 675. With almost 100,000 inpatient and outpatient encounters, Medicaid and self pay represents nearly 20% of the hospitals' total volume and the costs to treat those patients was over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances. Trinity Clinic has 11% Medicaid and self pay.

Intervention(s): Goal is to expand and enhance primary care with a minimum of 7 full time providers, physicians and mid-levels, to open access and lower wait time. A mid-level will work with nursing homes to improve care, better coordinate the appointments and accommodate the needs of the patients. Clinic hours and additional locations will be enhanced based on the demand for services, access to providers, wait time for appointments, and gap analysis providing additional new access capacity.

Need for the Project: Shortage of primary care providers has resulted in a waiting list for Medicaid and Medicare patients and extremely limited access for uninsured patients. All clinics are Level III Medical Homes and additional health care professionals will improve access.

Target Population: We anticipate at least 45,000 additional patient visits will be achieved by DY 5. Openings will be available to all patients with an expectation that 11% of the patient population will be Medicaid and/or uninsured.

Category 1 Expected Patient Benefits: TMF will hire 11 additional physicians and mid-level staff by DY 5 and will increase extended hours during the evenings and weekends. Space availability will be determined and measures implemented to best accommodate the patient population. Additional expansion will occur using current providers who will extend their work days. As the largest provider of primary care in Region 1 this will address the need for

additional primary care capacity. For reporting purposes the following visits are anticipated: DY 3: 12,000, DY 4: 16,000 and DY 5: 17,000.

Category 3 Outcomes: IT-6.1 Percent improvement over baseline of patient satisfaction scores is the outcome measure. Surveys provide feedback on accessing care in our facilities, set benchmarks, and trends over time. Our goal will be to identify predictors of patient satisfaction and experience with access to primary care using the CG-CAPHS survey.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Mother Frances Hospital – Jacksonville and Mother Frances Hospital – Winnsboro. By working as a health care system the impact on recruitment and access to providers is larger and possible for not only the primary service area but also our rural region thus expanding the impact to the RHP#1.

Additionally, the impact of the cost savings projects will make a significant impact on all three hospitals. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformational project be available to the rural hospitals. The lessons learned will be shared across the region.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

Project Narrative

Project Description: The goal of this project is to increase primary care access and capacity by expanding and restructuring clinic hours, decreasing the amount of time for patients to obtain appointments, and by enhancing same-day walk-in clinics to accommodate patients with acute illnesses and/or in need of preventive care. This project will expand the capacity of primary care to better accommodate the needs of the regional patient population and community. Expanding providers in our extended hour clinics will improve access and care for patients.

Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, 350 physicians and mid-levels representing 39 specialties in 36 clinic locations. MFH is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This is Region 1's only heart hospital. MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. Bed capacity for acute care and specialty care is close to 675. With almost 100,000 inpatient and outpatient encounters, Medicaid and self pay represents nearly 20% of the hospitals' total volume and the costs to treat those patients was over $65 million.

MFH-Tyler is a primary referral site for Palestine Regional Medical Center, Titus Regional Medical Center, and Hopkins Medical Center. Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care has three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics became free standing to meet the HURSA requirement. These clinics see 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of

MFH are from the OB clinic. 90% of all Medicaid and uninsured deliveries in Smith County are at MFH. All clinics are financially supported by TMF.

During the four year project, a minimum of 7 full time providers (physicians and mid-levels) will be recruited and begin seeing patients. Some additional positions will be part-time with the opportunity to move to full time if needed. Additionally, some current providers will expand their hours of clinical contact to increase access. Staff support, space, exam equipment, operational expenses, and laboratory services will be needed and expansion of some clinics will occur.

Why primary care expansion? Primary care providers serve as the patient's first point of entry into a health care system and are essential for providing timely preventive visits and effective coordination of health care services. The largest county in the region is Smith, with one in five children in poverty. It is bordered by Wood County to the north and Cherokee County to the south, each with one in three children living in poverty. Primary care access is critical to this population, with the fastest growing ethnic group regardless of age, being Hispanics. With rare exceptions, this is an overwhelmingly HPSA designated area for primary care and medically underserved areas. The target populations for this project will be Medicaid, Medicare, and indigent. Due to the location of this expansion all payers will use these services, also.

Goals and Relationship to Regional Goals:

Project goals:

- Expand primary care access and capacity
- Expand and enhance clinic hours
- Lower wait time for appointment
- Enhance same-day walk-in clinic

This project meets the following regional goals:

- Support hospitals' collaborative efforts to improve access to care and the health of the patients and families served
- To move toward the realization of the triple aim
    - Improve patient experience of care (including quality and satisfaction)
    - Improving the health of populations
- Addressing the gaps in access to care

Challenges: The primary challenge for this project will be to recruit health care professionals that are willing to work in a rural clinic setting and commit to working evening hours and weekends. Most of the current providers have full patient practices and little or no physical space to expand for new providers or extended hours. The shortage of primary care capacity also contributes to long waiting times for appointments. We also have inadequate space availability and will need to make modifications to serve the patient population. Trinity Clinic has opened new primary care clinics across East Texas in effort to provide preventative care close to home, but it is difficult to recruit providers to work in those clinics when larger communities are competing in the recruitment process and are able to pay higher wages. The

increase in patients seeking non-emergent care in the Emergency Department has forced the hospital to be on divert. Patients who need advanced level of care cannot always go to the hospital of their choice. Many patients fear treatment in a primary care clinic vs. the emergency department because they think they may have to immediately pay co-pays, etc. With educational outreach, the primary care setting can be, and should be, the right place for the right care at the right time.
Trinity Clinics are staffed by employed physicians who are on a common integrated IT platform with not only Mother Frances Hospital – Tyler but also MFH-Winnsboro and MFH-Jacksonville.
Delivery System Solutions: For the purpose of this project Trinity Mother Frances Healthcare System will *implement ways to expand the primary care capacity by: 1) improving the productivity of primary care providers by offering extended hours and restructuring workflow, thereby improving appointment wait times, 2) accelerating primary care workforce expansion by increasing the number of physician and non-physician practitioners to provide same day walk-in patient services with support staff, and 3) expanding providers at our direct care clinics in Smith and Van Zandt Counties at a minimum, as well as adding a provider at a rural clinic.*

The ultimate benefit of these initiatives is (1) to reduce the backlog of appointments (lowering the length of time for the third next available appointment) and little or no delay between when the need for urgent care presents and when the service is delivered through the use of direct care or referral to another primary care site*. In addition, it is anticipated that cost savings may be achieved when patients are provided appropriate access to their primary care providers rather than seeking care in an acute care hospital.* According to a study in the September/October Annals of Family Medicine, allowing patients evening and weekend appointments with their primary care doctors may reduce annual medical expenses. Total health care expenditures for patients with extended access to their primary care professional were 10.4% lower than for patients without expanded access, according to the study.

Using the new electronic medical record system, EPIC, which no other health system in the region has implemented, allows all providers in the system, including hospitals, to see the status of the patients care immediately. And, the patient is able to review his medical records and seek information directly with the provider without having to seek care in a traditional clinic setting. These features should help relieve overcrowding at some level and provide patients with critical information directly.

Another result of this access project will be the ability for our patients in rural areas to get into a health care location where needed services are provided either in a rural health care clinic, expanded clinic, or an urgent care clinic. The confidence in the level of care for these clinics is very high and the demand for services continues to grow and cannot be met without recruiting additional providers. *This will be accomplished by increasing the number of primary care providers in those underserved areas.*

Additionally, MFH is working in collaboration with Tyler Family Circle of Care, a primary care clinic that has applied for the FQHC Look-A-Like status. As part of the collaboration, MFH will support the expansion of another OB physician and a mid-level to improve access, cover hospital

deliveries, implement new protocols for delivery of babies, and decrease the wait time to get a prenatal appointment with a provider.

Five-Year Outcomes: The minimum expected five-year outcomes for this project are to increase access by at least seven new providers, provide increase in our medical home models when appropriate, increase the number of primary care visits by 45,000 over the 5 years, and establish or improve same day access for patients through our non-urgent center. The improvement in access for patients through expanding primary care will result in extended hours of access, more providers, and new sites of services, all of which will impact low income and elderly patients. It is essential to expand the primary care providers for OB services to improve outcome measures. The overall effect of expansion of primary care services will be an improvement in patient satisfaction scores.

Starting Point/Baseline: Starting Point/Baseline: The starting point/baseline for the primary care expansion initiative will be the implementation date of DY 2. The baseline is zero.
Rationale: Access to care is one the most discussed issues facing the Trinity Mother Frances Healthcare System today. As stated above, the growing concern about of an under-supply of primary care practitioners in the United States will likely accelerate demand for primary care in the coming years. According to the National Association of Community Health Centers' article from March 2009, Primary Care Access: an Essential Building Block of Health Reform, 60 million Americans, or nearly one in five, lack adequate access to primary care due to a shortage of primary care physicians in their communities.
We believe it is our responsibility to ensure access to health care and enhance the health of individuals to make improvements in quality and cost. Because primary care providers are typically the first point of contact for patients seeking health care, it is often described as the foundation of our health care system. Patients in our community have been asking for better access to primary health care services, better quality of care, and more health promotion and disease prevention services.

Project Components: We will implement all required core components.

a) Expand Primary Clinic space – will expand to meet the demands of the new providers
b) Expand primary care clinic hours –will do so to meet the demand for access and wait times
c) Expand primary care clinic staffing – will provide new staff and 7 providers

In an effort to reduce barriers to care and increase much-needed access to primary and preventative health care for patients in our service areas, we have selected these new initiatives addressing primary care expansion. Keeping pace with the escalating demand is a challenge; studies have shown that greater availability of primary care physician results in earlier diagnoses and lower mortality rates for certain forms of cancer, fewer cases of infant mortality and low birth weight, and lower overall mortality rates. Overall, improved access to comprehensive, quality health care services is important for increasing the quality of a healthy life for everyone. The hiring of new providers will require more space, expand clinic hours, and expand staffing.

The following milestones and metrics reflect the objectives and data to provide verifiable data of meeting the core components as required. These will in turn be reflected in the Category 3 outcomes by measuring improvement in patient satisfaction:
Milestones: P-1, P-5 (DY 2 & 3), P-8, I-12 (DY 4 & 5), I-13, I-10 (DY 4 &5)
Metric: P-1.1, P-5.1 (DY2, 3, 4), P-8.1, I-12.1 (DY4 & 5), I-13.1, I-10.1 (DY 4 & 5),

Unique Community Need identification numbers the project addresses:

- CN.1, insufficient access to primary and specialty health care services,
- CN.3, high rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer,
- CN.5, inappropriate emergency department utilizationCN.6 efficiency in and effectiveness of health care delivery will all be impacted by the expansion of primary care.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project is both a significant enhancement and a new initiative. By focusing on the needs the needs of the largest Medicaid and uninsured clinic in Smith County and probably the region, Tyler Family Circle of Care, and supporting their need for more providers it will have a major impact on access within a current program. And by adding a focus for nursing home patients and a walk-in clinic these are both new initiatives for MFH. Expansion of providers, space, and hours at many of the clinic sites will provide an expansion of current services to meet an unmet need to provide care.
Related Category 3 Outcomes Measure: The expected results of the primary care expansion initiative are to make access to healthcare easier by increasing the number of primary care providers, **adopting same-day scheduling to ensure timely appointments, and ensuring the ability to access primary care outside of regular hours. To demonstrate this, Trinity Mother Frances Healthcare System has selected the Related Category 3 Outcome Measure: OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores.**

There is currently no patient satisfaction program, surveys, or training within Trinity Clinic and there has not been for at least 5 years. We will implement the CG-CAPHS survey.
Trinity Clinic and Mother Frances Hospitals have implemented a new electronic medical record system, EPIC, to ensure that real time information is immediately accessible to all providers, regardless of whether they are hospital based or clinic based, and the cost for testing and results is not duplicated which will result in costs savings to all patients and payers. Staff and providers must have the tools to be better able to communicate and to take responsibility for patients feeling welcomed and have easy access for making appointments or having calls returned. Thus, implementing a robust customer service program for patients and clinical co-workers will enhance the ability to save money for patients, providers, and payers, but an additional cost saving will result in lowering the turnover rate of employees.
It will do little good to expand access if patients do not feel valued and have easy access and a support staff they feel comfortable calling for assistance rather than just coming into the office for everything or going to the emergency room for care.

Unfortunately, unless we train, implement, report, and hold individuals accountable, sustainable change to maximize the new access points is unlikely to occur. Consequently, implementing a patient satisfaction program is critical to maximizing the costs of expanding primary care and utilization by patients of the electronic medical record system.

Reasons/rationale for selecting the outcome measure:

In their 2005 Milbank quarterly article, Starfield, Shi, and Macinko find that "continuity of care, which implies that individuals use their primary source of care over time for most of their health care needs, is associated with greater satisfaction, better compliance, and lower hospitalization and emergency room use" (emphasis added).[44] Patient satisfaction with primary care services is largely related to utilization of primary care services. Understanding the strengths and needs for improvement by receiving patient feedback allows providers and staff to better understand how to tailor care delivery to meet their patients' needs. Also results in patients using primary care medical home clinics with appropriate referrals to specialty care access when needed.

We will utilize patient satisfaction surveys to provide feedback regarding the ease of accessing care in our facilities and to monitor satisfaction over time. Our goal will be to identify predictors of patient satisfaction and experience with access to primary care. There is no standardized patient satisfaction survey program in our clinics currently. This project will require an implementation of the CG-CAPHS patient satisfaction survey in these clinics.

Relationship to Other Projects and Measures: All of the projects of Mother Frances Hospital complement each other to meet the transformational goals and the three aims of CMS. As Donald Berwick said in Health Affairs, "Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations." We agree and fully support that through our projects for this program: Expand Primary Care, Expand Specialty Care, and Cost Containment.

The expansion of primary care capacity (094108002.1.1) will have a regional and system wide impact and will support and reinforce other DSRIP projects. Improved access to primary care results in improved patient outcomes, access at a lower cost point than the ER or urgent care center, the ability to seek care in an accredited primary care medical home, and engagement with an integrated health care delivery system with an electronic record system that includes primary care, accredited primary care medical homes, rural health care clinics, specialty care, urgent care centers, and hospitals.

Primary care is the baseline and initial access point to prevent the need for specialty care. However, when specialists are needed, the expanded specialty care project (094108002.1.2) will increase the base for referrals. Additionally, the need to improve the referral process will

1. Starfield B, Shi L, Macinko J: "Contributions of Primary Care to Health Systems and Health**."** *Milbank Quarterly* 2005, **83:**457-502.

be addressed as well as monitoring the number of new patients being served. These two projects working in tandem should help lower the rate of potentially preventable re-admissions.

A strong financial base through the redesign for cost containment project (094108002.2.1) will ensure the ability of the system to continue to be able to recruit primary care and specialty care providers. Expanding primary care will impact all elements of Category 4 by supporting patients to help keep their overall health strong so when they seek acute care services they will be stronger to fight preventable occurrences of any nature and will have a medical home to return to after being discharged from the hospital. Clearly, expanding the OB and mid-level programs at TFCC will impact quality outcomes and Domain F in category 4.

Relationship to Other Performing Projects in the RHP1: Increasing primary care is a major initiative of the entire region. Many of the other regional partners have selected this project, including Andrews Center, East Texas Medical Center, St. Michaels Health System, Titus Regional Medical Center, The Burke Center, University Physicians, and Hunt Regional Medical Center. The geographic area covered in this region lends itself to multiple entities expanding primary care. It is our full intention to participate and lead some of the learning collaborative opportunities to share best practices. Community needs for primary care include CN1, 3, and 5 as listed.

Currently, Trinity Clinic and Mother Frances Hospital are the only facilities that have Level III NCQA certified Primary Care Medical Homes. A number of other health care facilities are hoping to achieve this and we feel we will be a strong asset for this process in the region. Expansion of primary care will also support palliative care development and telemedicine for pediatric and adult medicine.

Plan for Learning Collaboratives: Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. Mother Frances Hospitals participates in several learning collaboratives with other hospitals including Health Care Coalition of Texas (hospitals across Texas- all not-for profit) and Texas Coalition for Access which includes Baylor, Memorial Herman, and Scott and White. MFH believes in and supports the value of learning collaboratives. MFH will support the plans of Region 1.

The system pledges to develop, support, participate, and lead the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to have our collaboratives inform others of our experiences and best practices acquired and learn from others in the state. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, Titus Regional, and MFH, have met to discuss the project planning process and selection of projects.

Project Valuation: The value of this project is based on the broad impact that additional primary providers would have on the identified community needs. Increasing the number of

primary care providers directly improves the shortage of primary care providers in the community. Additional primary care providers will directly impact those communities that are medically underserved. Being a largely rural community, long drives to seek care at a primary care provider increase the cost of care for patients. Patients able to make timely appointments for primary care near their homes will be more likely to see a primary care provider, increasing the probability of early diagnoses and treatment and reducing preventable hospitalizations and health care costs. Patients with a regular primary care provider are more likely to effectively manage chronic conditions, reducing preventable hospitalizations and increasing the patient's general health status. More convenient and affordable access to primary care providers will also increase the number of patients who seek medical care in an appropriate setting, decreasing the utilization of emergency departments for non-emergency health care services. This will free emergency department resources for true emergency services, consequently improving care and decreasing wait times for patients with more urgent medical needs. Attracting and retaining primary care providers in rural areas is a recognized challenge. In order to attract the necessary skilled personnel, we have considered the need for appropriate salaries as well as appropriate equipment and supplies.

While costs of the program are not the only elements of a project valuation, the cost for hiring 11 new providers and support staff as well as expanding access using new current providers to increase the number of hours of patient contact, using the current area salary ranges are a significant portion of the valuation. But clearly the amount of new access to care is extremely substantive and the same quality of care and outcome measurements will be offered and monitored for all patients regardless of their ability to pay for services. With 10% anticipated to be Medicaid and indigent the cost savings will be significant. Additionally, the sustainability of the program beyond the waiver is important and has been taken into consideration.
Trinity Clinic is the provider of choice and has the largest number of providers in a group practice in east Texas. The public seeks care at these clinics first and the demand for care when it is not accessible further supports that the public will use these new access points. Again, Mother Frances Hospital sees over 75,000 patients in their ED, which is estimated to be about 15,000 more patient visits than the other emergency departments providing options that will lessen the burden on the ED and save costs is valuable.
Mother Frances Hospital is also committed to being a leader in sharing information with other providers as they begin the process of developing clinical practices to ensure they also maximize the benefits of this program for the Medicaid population. Clinical practices and customer service tools will be shared as part of the learning programs.
Project Collaboration: Mother Frances Hospital – Tyler collaborated with Mother Frances Hospital – Jacksonville and Mother Frances Hospital – Winnsboro. By working as a health care system the impact on recruitment and access to providers is larger and possible for not only the primary service area but also our rural region thus expanding the impact to the RHP#1.

Additionally, the impact of the cost savings projects will make a significant impact on all three hospitals. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformational project be available to the rural hospitals. The lessons learned will be shared across the region.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

094108002.1.1	1.1.2	1.1.2, A,B,C	EXPAND PRIMARY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Establish additional/expand existing/relocate primary care clinics. Metric 1 P-1.1: Number of additional clinics or expanded hours or space. Baseline: 0 - New clinic service, so there are no providers, staffing or patient visits for this service as of 9/30/12. Goal: Establish a primary care clinic with same day access in an existing primary care location and begin recruiting efforts for staffing providers. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by	**Milestone 3 P-5:** Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites. Baseline: Number of providers and clinics as of 9/30/13. Goal: Increase number of providers by at least four with staffing in order to expand service. Data Source: Documentation of completion of all items described by the RHP plan for this measure.		**Milestone 6 P-5:** Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites. Baseline: Number of providers and clinics as of 9/30/14. Goal: Increase number of providers by at least two with staffing in order to expand service. Data Source: Documentation of completion of all items described by the RHP plan for this measure.	**Milestone 10 I-12:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 9/30/12. Goal: 17,000 patient visits over baseline for a total of 45,000 over the period of the project. Data Source: Registry, EHR, claims or other Performing Provider source. **Milestone 10 Estimated Incentive Payment: $1,292,303**

094108002.1.1	1.1.2	1.1.2, A,B,C	EXPAND PRIMARY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Performing Provider. **Milestone 1 Estimated Incentive Payment: $1,429,797** **Milestone 2 P-5:** Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 P-5.1: Documentation of increased number of providers and staff and/or clinic sites. Baseline: Number of providers as of 9/30/12. Goal: Hire an additional OB primary care provider and one mid-level to increase capacity to deliver care. Hire one		**Milestone 3 Estimated Incentive Payment: $1,039,888** **Milestone 4 P-8:** Develop an automated tracking system for measuring time to next available offered appointment. Metric 1 P-8.1: Documentation that providers and staff are aware of next available appointment time using real time scheduling data, to ensure that patients can receive primary care services according to acuity and need. Baseline: 0 - New system in 2013 Goal: Establish procedure for	**Milestone 6 Estimated Incentive Payment: $782,183** **Milestone 7 I-12:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 0 – All new providers, 9/30/12. Goal: 16,000 patient visits over baseline or 4,000 over DY3 Data Source: Registry, EHR, claims or other Performing Provider source.	**Milestone 11 I-10:** Enhance patient access to primary care services by reducing days to third next-available appointment. Demonstrate improvement over prior reporting period. Metric 1 I-10.1: Third Next-Available Appointment: The length of time in calendar days between the days a patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an

094108002.1.1	1.1.2	1.1.2, A,B,C	EXPAND PRIMARY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
primary care provider in a Rural Health Clinic and two other providers. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation. **Milestone 2 Estimated Incentive Payment: $1,429,798**	tracking appointment opportunity and education on processes. Data Source: Documentation of Performing Provider policies for assessing and communicating time to next available appointment and response to patient care needs reporting and communication tool. Performing Provider administrative records from patient scheduling system and sign in sheets for education of staff, managers and providers in expanded sites. **Milestone 4 Estimated Incentive Payment: $1,039,888** **Milestone 5 I-12:** Increase		**Milestone 7 Estimated Incentive Payment: $782,183** **Milestone 8 I-13:** Enhanced capacity to provide urgent care services in the primary care setting. Metric 1 I-13.1: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 days of calendar days of request. Demonstrate improvement over baseline rates. Baseline: DY3 number of visits. Goal: Establish baseline of urgent care services provided at site and increase the number of visits by 2,000 with	average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be 7 calendar days (lower is better), but depending on the Performing Provider's starting point, that may not be possible within 4 years. Baseline: Wait time as of 9/30/13. Goal: Reduce waiting time for 3rd next-available for site by 1 day. Data Source: Practice management or scheduling systems. **Milestone 11 Estimated Incentive Payment: $1,292,303**

094108002.1.1	1.1.2	1.1.2, A,B,C	EXPAND PRIMARY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 patient visits Goal:12,000 patient visits **Milestone 5 Estimated Incentive Payment: $1,039,889**		the new providers. Data Source: Registry, EHR, claims or other Performing Provider scheduling source. **Milestone 8 Estimated Incentive Payment: $782,183** **Milestone 9 I-10:** Enhance patient access to primary care services by reducing days to third next-available appointment. Demonstrate improvement over prior reporting period. Metric 1 I-10.1: Third Next-Available Appointment: The length of time in calendar days between the days a patient makes a request for an appointment with a	

094108002.1.1	1.1.2	1.1.2, A,B,C	EXPAND PRIMARY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be 7 calendar days (lower is better), but depending on the Performing Provider's starting point, that may not be possible within 4 years. Baseline: Wait time as of 9/30/12. Goal: Reduce waiting time for 3rd next-available for site by 2 days. Data Source: Practice management or scheduling	

094108002.1.1	1.1.2	1.1.2, A,B,C	EXPAND PRIMARY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			systems. **Milestone 9 Estimated Incentive Payment: $782,184**	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* **$2,859,595**	Year 3 Estimated Milestone Bundle Amount: **$3,119,665**		Year 4 Estimated Milestone Bundle Amount: **$3,128,733**	Year 5 Estimated Milestone Bundle Amount: **$2,584,606**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* **$11,692,599**				

Project Option: 1.9.2 Expand Specialty Care
Project Identifier: 094108002.1.2 (Pass 1)
Performing Provider Name/TPI: Mother Frances Hospital/0941080002

Project Abstract

Provider Description: Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. . With almost 100,000 inpatient and outpatient encounters, Medicaid and self pay represents nearly 20% of the hospitals' total volume and the costs to treat those patients was over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances. Trinity Clinic has 11% Medicaid and self pay.

Intervention(s): The goal of this project is to increase the capacity for specialty care services by adding a minimum of 7 new providers and the availability of targeted specialty providers to better accommodate the high demand for specialty care services for Medicaid and uninsured so that patients have increased access to specialty services as well as all payers. 40% of the patients entering the emergency room are admitted and need specialty care.

Need for the Project: A gap analysis will determine the specialty services needed but the growth in hospital care demands more specialists and providers who are willing to travel to regional clinics to better serve their patients with preventative medicine. It is expected this will set the benchmark for expansion across the system. Early indications are at least 1 cardiologist, 2 pulmonologist, and 1 gastroenterologist will be needed.

Target Population: We anticipate reaching not only Medicaid and indigent but all payers to lower the rate of for inpatients that are ready for discharge and are at risk for potentially preventable readmissions. Target populations are found within an 11 county radius. Trinity Clinic has a 11% Medicaid and self pay. Our goal is to reach 23,000 patient visits.

Category 2 Expended Patient Benefits: The project seeks to provide the targeted patients access creating the potential of 6,000 DY3, 8,000 DY4, and 9,000 DY5 for a total of 23,000 patient visits.

Category 3 Outcomes: IT-3.1 All cause – 30 day readmission rate-NQF 1789. Our goal is to reduce the readmission rate over the baseline.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Mother Frances Hospital – Jacksonville and Mother Frances Hospital – Winnsboro. By working as a health care system the impact on recruitment and access to providers is larger and possible for not only the primary service area but also our rural region thus expanding the impact to the RHP#1.

Additionally, the impact of the cost savings projects will make a significant impact on all three hospitals. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformational project be available to the rural hospitals. The lessons learned will be shared across the region.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

Project Narrative

Project Description: : The goal of this project is to increase the capacity for specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services for Medicaid and uninsured. According to Capital Healthcare Planning report from 2009 there is a need for a multitude of specialty care including among other key areas, cardiology, pulmonary, gastroenterology, cancer care, fetal medicine, and neurology and rehabilitation medicine.

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about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances. Trinity Clinic has a Medicaid and self pay percentage of 11%.

Why specialty medicine expansion? Mother Frances Hospital Emergency Department is one of the largest in the region and sees more patients in Smith County than any other ER. 40% of the people coming to the emergency room are admitted and will have a need for specialty care. The demand for providers who see patients in an outpatient setting to also provide coverage in the ER and on a daily basis in the hospital is growing and impacting access for outpatient services. MFH is the hospital of choice for inpatient services in Smith County and most of the region. This again, increases pressure to provide access for specialty care in the inpatient setting.

By recruiting key additional providers, the goal is to allow all providers to see more patients in the outpatient setting and to provide inpatient services. MHF is uniquely positioned to continue to grow in specialty services. Over the last 17 years, Trinity Clinic has become the largest specialty group practice in this region and did so when no other facilities were willing to recruit specialty providers. Patients in the clinic and hospital settings trust and value the compassionate and quality of care they receive in both the outpatient and inpatient setting. There is, however, no doubt that having to wait weeks, and in some specialty areas months, to get an appointment is having an impact on improving the rate of potentially preventable admissions, potentially preventable readmissions, and patient care outcomes. A gap analysis will clearly define long-term provider needs.

Goals and Relationship to Regional Goals: Mother Frances Hospital and Trinity Clinic have worked to develop a strong team of providers with over 200 specialists representing 39 specialties in 36 locations as part of a group of 350 healthcare provider groups. They have continued to expand the health care offerings to rural communities as well as the major population center of Tyler. Specialized services include cardiology, pulmonary, neurology, surgery, emergency care, and many other specialties. These specialty services are currently in place for inpatient, but must expand to meet the demand for growth. Outpatient services must also be expanded to lower wait times for patient appointments and improve access across the region. The receipt of national awards for service, care, and quality has set the bar very high for recruitment of providers with a commitment to provide high quality and value-based care while being patient-centered.

Goals and Relationship to Regional Goals:
Project goals:

- Expand specialty care access and capacity
- Expand and enhance both inpatient and outpatient services
- Enhance specialty services to the region

This project meets the following regional goals:

- Support hospitals' collaborative efforts to improve access to care and the health of the patients and families served
- To move toward the realization of the triple aim
    - Improve patient experience of care (including quality and satisfaction)
    - Improving the health of populations
- Addressing the gaps in access to care

Challenges: The primary challenge for this project will be to recruit physicians that will not only provide outpatient services but will have inpatient hospital coverage requirements and, in many instances, will be required to travel to some of the regional sites to provide care. The competition for recruitment of specialists is great across the country. It is even more challenging when you need them to work in a rural area. Salary levels, salary guarantees, and recruitment costs are always higher in our region than in other areas of the state. Thus, the level of economic support to ensure the continuity of care over time is more costly.

The last Trinity Clinic pulmonologist to work in an outpatient setting was in 2007. In July 2012, Pulmonary Associates of East Texas closed, leaving the community with two fewer pulmonologists who had been seeing over 880 referrals from MFH annually. The pulmonologist recruited will be practicing as a solo outpatient physician until we can recruit a second provider. While Trinity Clinic does have a team of three inpatient pulmonologists, recruiting the initial providers for outpatient services has challenges for call coverage and vacation coverage.

All providers recruited will be high level caregivers who are eager to work with high benchmarks and accountability to implement best practices, including cost containment measures.

Delivery System Solution: East Texas is one of the fastest growing senior populations. Tyler, in Smith County, has been designated as a retirement community, the first in the state, with a goal of attracting seniors to retire here. Capital Healthcare Planning reports that 54% of the patients seen at MFH are Medicare, 6.3% Indigent, and 13.8% Medicaid. As such, 70% of the patients seen are part of the government payment system, and that does not include the indigent patient population. All of these groups are targeted in the specialty care expansion and the providers who are recruited will take Medicaid, Medicare, and indigent patients as well as other payers.

MFH is a Top 100 Hospital for Stroke Management and received recognition from the Joint Commission. To improve the access to the specialty care practice for Cardiovascular Services, TMFHC determined the need to expand the four-member Trinity Clinic Cardiology practice and to open a Trinity Clinic Electrophysiology practice, a total of ten physicians by the end of calendar year 2013. The need for this expansion is based on the physician needs assessment by Capital Planning. This project will fund the recruitment and establishment of the final members of the cardiology group.

First, targeted in DY2 will be recruiting, hiring, staffing, and training for an additional cardiologist who will join a team that is currently providing services to the region and will have clinic hours in Smith County, also. This person and their team will support regional clinics in Canton, Athens, Jacksonville, Kilgore, and Winnsboro on a rotating basis. This will keep access to care close to home for a growing senior population.

Second, to restore pulmonary services that have left the area and to provide continued access to the specialty care practice for pulmonary medicine, Trinity Clinic, with support from MFH, will recruit a team to provide pulmonary care based in an outpatient setting. To meet the needs of our current patient referrals without significant delay we will recruit one physician, one full- time registered nurse and one office assistant to create a pulmonary medicine clinic. The gap analysis will determine the number of providers needed over the course of this project.
Third, we also support the fastest growing liver clinic in East Texas and are recruiting and expanding our gastroenterology group to include one additional provider who will do both gastroenterology and also provide hematology services with staffing. There is the potential for opening a new clinic with this provider also.
Fourth, there is an immediate need for a physical medicine and rehabilitation provider to be on site within the first year. The needs of an aging population have outpaced the ability of the current providers to meet those needs.
Fifth, in DY 3 and 4, the decision on what types of specialists will be recruited will be based on the gap analysis. The commitment for this project over the four years is for at least 7 new specialists to be recruited and practices in place during the scope of this project. More providers, physicians and mid-levels, may be added, depending on the gap analysis and the ability to recruit the needed specialists.
In a region where obesity and diabetes is very high, the need for sleep medicine expansion is being reviewed currently. Potentially an expansion of that specialty could occur in DY 2 or 3.
Oversight of this project will be done with a multidisciplinary team including providers, nursing, case management, finance, quality, and administration to ensure that the project is patient-centered and provides expanded access with accountability for costs and quality of care.
Five-Year Outcomes: The expected five-year outcome for this project is to increase staffing by, at a minimum, seven (7) new providers including cardiology, pulmonary, gastroenterology, and pain management, many of whom will be working in the region, hospital, and outpatient clinics. A system will be designed and put into place to improve referrals to specialists from both the hospital and primary care settings and to track the time for appointments. Training on referral process will include both specialty clinic expansion and all the primary care clinics. Key providers who develop best practices will be providing training and shared learning experiences to others in the region. The Category 3 outcome targeted is impacting the 30-day potentially preventable readmissions rates.

Starting Point/Baseline: Anticipating the implementation of the Medicaid Waiver, MFH embarked on an expansion of specialty care for cardiology in January 2012. At that time, Trinity Clinic had only 4 cardiologists. By July 2012, Trinity Clinic had grown to six cardiologists, and by September a total of seven cardiologists and two electro physiologists. Baseline starting time is DY 2, September 30, 2012

All new providers will have a baseline of zero patients regardless of which year they join, and their growth will be reflected as a cumulative number over time. Training for staff to improve appointment times will also be new so the baseline for that training will also be zero. The number of patient visits will be tracked over the entire period and reported.

Rationale: We will begin by doing a gap analysis to identify gaps in high-demand specialty areas to best determine where to build up the supply of specialists to meet demand for services and improve specialty care and use the Capital Healthcare Planning report for current recruitment. While many of the target specialty areas are clear with current data and patient wait times for an appointment, it is critical that expansion and new services be viable and have the ability to continue after the waiver.

Training care providers and staff on processes, etc., for referrals and consultations into selected medical specialties increases the capacity to consistently and uniformly manage all referrals into medical specialties. Reports will assess the referral management system efficiency and give clear data on the impact of the new providers. Increasing the number of specialists to meet the primary demand and referral demand will allow patients to receive more timely services. Measuring increased volume of visits is a method to assess the ability for the performing provider to increase capacity to provide care. By selecting the core components of extended hours; more specialty clinic locations; transparent standardized referrals, and implementing quality improvement methodologies, MFH will be well positioned to meet several of the community needs that have been identified in Region 1.

Core Project Components: We will implement all core project components.

a) Increase service availability with hours – adding a minimum of 7 providers will open more opportunity and provide greater access in the hospital setting
b) Increase number of specialty clinic locations – adding clinic days in the region and at the hospital
c) Implement transparent, standardized across the system – transformational care order sets requires standardization of protocols and reporting
d) Conduct quality improvement for project using methods such as a rapid cycle improvement. Activities may include, but are not limited to identifying project impacts, identifying "lessons learned", opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety –net populations – a multidisciplinary team will work on this process

Milestones: P-1, P-11 (DY 2, 3, & 4), P-2 (DY 2, 3, & 4), P-21 (DY 3, 4, & 5), P-5 (DY 4 & 5), I-23 (DY 4 & 5), I-21.
Metric: P-1.1, 1-11.1 (DY 2, 3, & 4), P.2.1 (DY 2, 3, &4), P-21.1 (DY 3, 4, &5), P-5.1 (DY 4, & 5), I-23.1 (DY 4 & 5), I-21.1

Community Needs: To meet the community need of insufficient access to specialty care (CN1), high rates of chronic disease (CN3), high costs of potentially preventable hospitalizations/re-admissions, and inappropriate emergency department utilization are all addressed by opening and expanding specialty clinics to improve access for targeted populations in areas where there are gaps in specialty care. This also allows for enhanced care coordination for patients requiring intensive specialty services.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: The expansion of specialty clinics will be an enhancement for services in the region and in the primary service area. Wait times for appointments and needs for hospital referrals to ensure that potentially preventable readmissions are address cannot happen with the expansion of specialty care in Region 1. Finally, implementing an outpatient pulmonology clinic will be a new service. Having continuity of care from the inpatient stay to the outpatient clinic for specialty care will be both new in some areas and expanded but all should help with potentially preventable readmissions. New specialty provider services are needed for inpatient care due to growth from transfer patients from regional hospitals.

Related Category 3 Outcome Measures: To demonstrate improved access to specialty care, Mother Frances Hospital has selected outcome domain – 3; Potentially Preventable Re-admissions-30 day readmission rates (PPRs) and improvement target; 3.1 all cause 30 day readmission rate – NQF 1789.

Reasons/rationale for selecting the outcome measures: In their 1999 article, Philbin, et al found that "The benefits of cardiology specialty care include lower CHF readmission rates".[45] The goal is to show that having access to specialty care will impact readmission rates. In this case particularly, access to cardiology and pulmonary services will be a strong focus as well as others as identified in the process. There are gaps in services based on current patient wait times and unavailability of some services like outpatient pulmonology. All of these will target the outcome measure success.

Relationship to Other Projects and Measures: All of the projects of Mother Frances Hospital complement each other to meet the transformation goals and the three aims of CMS. As Donald Berwick said in Health Affairs, "Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the 'Triple Aim': improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations." We agree and fully support that through our projects for this program: Expand Primary Care 094108002.1.1), Expand Specialty Care (094108002.1.2) , and Cost Containment (094108002.2.1).

Relationship to Other Performing Providers' Projects in RHP1: With 89% of the counties in the region having primary care shortages it is a responsibility for MFH to support the growth of new primary care across the region and provide the specialists that are needed in the region. A number of other providers are seeking to recruit and expand specialty services, including ETMC Tyler, Pittsburg and Henderson, University Physicians, and others. Because of the large area and the geographical location of the requests, there is little doubt of the need for multiple projects. MFH will continue to work with any provider and has discussed expansion needs with providers

[45] Philbin, E. F., MD; Weil, H. F. C., MD; Erb, T. A., BS; and Jenkins, P. L., PhD: "Cardiology or primary care for heart failure in the community setting: process of care and clinical outcomes". Chest. 1999 Aug; 116(2):346-54.

in the region, and ways we can meet the community needs assessment in rural areas. Projects across the region addressing CN1, CN3, CN4, CN5, and CN6 will be impacted.

Plan for Learning Collaboratives: Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. Mother Frances Hospital participates in several learning collaboratives with other hospitals, including Health Care Coalition of Texas (hospitals across Texas, all not-for profit) and Texas Coalition for Access, which includes Baylor, Memorial Herman, and Scott and White. MFH will develop, support, participate, and lead when needed the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to have our collaborative inform others of our experiences and best practices acquired and learn from others in the state and our region including with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital and, Titus Regional. Additionally, MFH will support the learning collaborative of Region 1.

Project Valuation: The value of this project is based on the broad impact that additional specialty providers will have on the identified community needs. Increasing the number of specialty providers directly impacts the shortage of specialty care providers in the community. More specialty providers will impact areas medically underserved. As a large rural community, long drives to seek care at specialty providers increase the cost of care for patients. Patients able to make timely appointments near their homes will be more likely to see an appropriate care provider, increasing the probability of early diagnoses and treatment, reducing preventable hospitalizations and health care costs. Patients with access to specialty providers are more likely to manage chronic conditions, reducing preventable hospitalizations and increasing the patient's general health. Convenient access to specialty providers will also increase the number of patients seeking care in an appropriate setting, decreasing utilization of emergency departments for non-urgent services. This frees resources for emergency services and improving care in the ED. Attracting and retaining specialty providers in rural areas is a recognized challenge. To attract the necessary skilled personnel, we have considered the need for appropriate salaries as well as appropriate equipment and supplies.

Trinity Clinic specialty services are open to all providers in the region. In fact, 40% of the admissions of Mother Frances Hospital come from outside the primary service area of Smith County. Thus, the ability to have open referrals for other hospitals in the region that are transferring patients to a higher level of acuity of care is paramount to patient care and lowering the length of stay thus cutting costs for payers. Mother Frances Hospital is the primary referral hospital for two critical access hospitals in east Texas and is the primary referral for at least three other rural hospitals all with less than 100 beds and few specialists.

Having expanded specialty care for inpatients on a faster basis should also reduce length of stay in the hospital.

Transfers from all of these acute care hospitals are done without regard to payer source so Medicaid is accepted from all sources.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Mother Frances Hospital – Jacksonville and Mother Frances Hospital – Winnsboro. By working as a health care system the impact on recruitment and access to providers is larger and possible for not only the primary service area but also our rural region thus expanding the impact to the RHP#1.

Additionally, the impact of the cost savings projects will make a significant impact on all three hospitals. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformational project be available to the rural hospitals. The lessons learned will be shared across the region.

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094108002.1.2	1.9.2	1.9.2, A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1: Conduct specialty care gap assessment based on community need. Metric 1 P1-1.1: Documentation of gap assessment. Demonstrate improvement over prior reporting period as of September 30, 2012.. Baseline: Providers as of September 30, 2012. Goal: Determine number of providers needed in key areas, such as cardiology, pulmonology, endocrinology, and sleep medicine, gastroenterology, neurology, etc.. Date Source: Gap Analysis.	**MILESTONE: 4 P-11:** Launch /expand a specialty care clinic. Metric 1 P-11.1: Establish/expand specialty care clinics. Baseline: Number of patients served by specialty care clinic prior to September 30, 2012. Goal: 1) Expand specialty clinics by three providers with staffing and office setup. 2) Open one specialty clinic internally to support cardiology patient monitoring and evaluation based on gap assessment. Data Source: Documentation of new/expanded specialty care clinic.	**MILESTONE: 8 P-11:** Launch /expand a specialty care clinic. Metric 1 P-11.1: Establish/expand specialty care clinics. Baseline: Number of patients served by specialty care clinic prior to 10/1/2014. Goal: Expand by a minimum of two providers, based on gap assessment along with staffing and location needs. Data Source: Documentation of new/expanded specialty care clinic. **Milestone 8 Estimated Incentive Payment: $938,620**	**Milestone 13 P-5:** Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment. Metric 1 P-5.1: Generate and provide reports on average referral process time and/or wait time from receipt of referral to actual referral appointment. a. Numerator: Sum, for all referrals, of the number of days between when request for referral is received from referring provider and the referral appointment during the reporting period. b. Denominator: Total number of referrals during the reporting period.

094108002.1.2	1.9.2	1.9.2, A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 Estimated Incentive Payment: $1,429,797 **MILESTONE: 2 P-11:** Launch /expand a specialty care clinic. Metric 1 P-11.1: Establish/expand specialty care clinics. Baseline: Number of specialty care clinics for month of September 2012. Goal: 1) Expand cardiology by recruiting at least one provider, move to new building and provide staffing. 2) Implement outpatient pulmonology clinic and recruit	**Milestone 4 Estimated Incentive Payment: $1,169,874** **Milestone 5 P-2:** Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Metric 1 P-2.1: Training for staff and providers on referral guidelines, process and technology. a. Numerator: Number of staff and providers and trained and documentation of training materials. b. Denominator: Total number of staff and providers working	**Milestone 9 P-2:** Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Metric 1 P-2.1: Training for staff and providers on referral guidelines, process and technology. a. Numerator: Number of staff and providers and trained and documentation of training materials. b. Denominator: Total number of staff and providers working in specialty care and medical specialty clinics. Baseline: Number from DY3. Goal: Train 100% of new providers and staff in DY4.	Baseline: Data as of DY4. Goal: Improve by one day. Data Source: EHR and generated reports on process. **Milestone 13 Estimated Incentive Payment: $1,292,303** **Milestone 14 P-21:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each

094108002.1.2	1.9.2	1.9.2, A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
at least one pulmonologist, open new clinic space and provide staffing. 3) Expand gastroenterology and hepatology services by recruiting one new provider and staff. 4) Expand Pain Medicine and Rehabilitation by recruiting one new provider with staff. Data Source: Documentation of new/expanded specialty care clinic. **Milestone 2 Estimated Incentive Payment: $1,429,798** **Milestone 3 P-2:** Train care providers and staff on processes, guidelines and	in specialty care and medical specialty clinics. Baseline: Number from DY2. Goal: Train 100% of new providers and staff in DY3. Data Source: Log of specialty care personnel trained and Curriculum for training. **Milestone 5 Estimated Incentive Payment: $1,169,874** **Milestone 6 P-21:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face		Data Source: Log of specialty care personnel trained and Curriculum for training. **Milestone 9 Estimated Incentive Payment: $938,620** **Milestone 10 P-5:** Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment. Metric 1 P-5.1: Generate and provide reports on average referral process time and/or wait time from receipt of referral to actual referral appointment. a. Numerator: Sum, for all referrals, of the number of	participating provider should publicly commit to implementing these improvements. Metric 1 P-21.1: Participate in semi-annual face-to face meetings or seminars organized by the RHP. Baseline: Attended two in DY4. Goal: Participate 100%. Data Source: Documentation of semiannual meetings, including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 14 Estimated Incentive Payment: $1,292,303** **Milestone 15 I-23:** Increase specialty care clinic volume of

094108002.1.2	1.9.2	1.9.2, A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Mother Frances Hospital				094108002
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Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
technology for referrals and consultations into selected medical specialties. Metric 1 P-2.1: Training for staff and providers on referral guidelines, process and technology. a. Numerator: Number of staff and providers and trained and documentation of training materials. b. Denominator: Total number of staff and providers working in specialty care and medical specialty clinics. Baseline: No staff trained as of 9/30/12- New training. Goal: Train 100% of specialists and staff hired in DY2 and 100% of Trinity Clinic primary care provider managers.	meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 P-21.1: Participate in semi-annual face-to face meetings or seminars organized by the RHP. Baseline: 0- No meetings held. Goal: 1) Participate 100%. 2) Provide leadership training for presentation development. 3) Initiate leadership group for presenting and mentoring on	days between when request for referral is received from referring provider and the referral appointment during the reporting period. b. Denominator: Total number of referrals during the reporting period. Baseline: Data from DY3. Goal: To improve by 20%. Data Source: EHR and generated reports on process. **Milestone 10 Estimated Incentive Payment: $938,620** **Milestone 11 P-21:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning	visits and evidence of improved access for patients seeking services. Metric 1 I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) a. Total number of visits for reporting period. Baseline: Number of visits reported in DY4 Goal: 9,000 for the year for a project total of 23,000 Data Source: Registry, HER, claims or other Performing Provider source. **Milestone 15 Estimated Incentive Payment: $1,292,303**

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Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Log of specialty care and primary care personnel trained and Curriculum for training. **Milestone 3 Estimated Incentive Payment: $1,429,798**	best practices. Data Source: Documentation of semiannual meetings, including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 6 Estimated Incentive Payment: $1,169,874** **Milestone 7 I-23:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2)		around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 P-21.1: Participate in semi-annual face-to face meetings or seminars organized by the RHP. Baseline: Attend two meetings. Goal: Participate 100%. Data Source: Documentation of semiannual meetings, including	

094108002.1.2	1.9.2	1.9.2, A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	a. Total number of visits for reporting period. Baseline: Number of visits from 9/30/12. Goal: Increase by 6,000. Data Source: Registry, HER, claims or other Performing Provider source. Data Source: **Milestone 7 Estimated Incentive Payment: $1,169,875**		meeting agendas, slides from presentations, and/or meeting notes. **Milestone 11 Estimated Incentive Payment: $938,620** **Milestone 12 I-23:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) a. Total number of visits for reporting period. Baseline: Number of visits from 9/30/12.	

094108002.1.2	1.9.2	1.9.2, A, B, C, D	EXPAND SPECIALTY CARE CAPACITY	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Goal: Increase by 8,000. Data Source: Registry, HER, claims or other Performing Provider source. Data Source: **Milestone 12 Estimated Incentive Payment: $938,620**	
Year 2 Estimated Milestone Bundle Amount: **$4,289,393**	Year 3 Estimated Milestone Bundle Amount: **$4,679,497**		Year 4 Estimated Milestone Bundle Amount: **$4,693,100**	Year 5 Estimated Milestone Bundle Amount: **$3,876,909**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* **$17,538,898**				

Project Option: 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region.
Project Identifier: 094108002.1.3 (Pass 2)
Performing Provider Name/TPI: Mother Frances Hospital /094108002

Project Abstract

Provider Description: Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. With almost 100,000 inpatient and outpatient encounters, Medicaid and self pay represents nearly 20% of the hospitals' total volume and the costs to treat those patients was over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by TMF. Trinity Clinic has 11% Medicaid and self pay.

Intervention(s): The goal of this project is to expand and enhance the capacity of providers in the region to manage complex pediatric patients locally through timely access to pediatric subspecialists and specialists via telemedicine. Eligible providers will have access to education services and a single-access phone number allowing the local provider to connect with the desired pediatric certified physician specialist, as well as the ability to transfer information by videoconferencing, transmission of still images and remote monitoring.

Need for the Project: Currently, approximately 80% of the specialty and subspecialty care must go at least 90 miles for a pediatric specialty consultation. This causes undue delay in diagnosis and treatment decision for the youngest of our patients already seeking care in an emergency room.

Target Population: We anticipate that 650 patient visits will be targeted. The target populations are those who seek care in the emergency room, through the labor and delivery department, NICU, or at pediatric patients of the hospital and clinics. Pediatric Medicaid constitutes an estimated amount of 45% of the target population.

Category1 Expended Patient Benefits: The project seeks to provide 650 pediatric telemedicine visits/consults with local access to high level of pediatric specialty and subspecialty care and support in DY 3 through DY 5. Annually the projects are: DY3: 175, DY4: 225, and DY5: 250 visits. The program will allow families to have a consult with a certified physician pediatric specialist without having to travel to the Dallas/Fort Worth area. More appropriate patient care plans will be developed with advice and counsel of a higher level of care providers in conjunction with the local provider.

Category 3 Outcomes: IT-9.2ED appropriate utilization. Our goal is to reduce the number of transfers by providing pediatric specialty and subspecialty consultations in the ED.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Trinity Clinic and ContinueCARE Hospital. By working as a health care system the impact on recruitment and access to providers is made possible for not only access to pediatric telemedicine services in the ED but also to improve care transitions and provide patient navigation services. Again, these programs will impact patient care across the RHP#1 and access for both inpatient and outpatient services.

Additionally, the impact of the cost savings projects will make a significant impact on these two entities also, even though their funding was not directly applied to that project. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformable project be available to the rural hospitals and out-patient services.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

Project Narrative

Project Description: This project will expand and enhance the capacity of providers in the region to manage complex pediatric patients locally through timely access to pediatric subspecialists and specialists via telemedicine. Eligible providers will have access to education services and a single-access phone number allowing the local provider to connect with the desired subspecialist, as well as the ability to transfer information by videoconferencing, transmission of still images and remote monitoring. Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility that provides highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This bed capacity for acute care and specialty care needs is close to 675. With almost 100,000 inpatient and outpatient encounters, Medicaid and self pay represents nearly 20% of the hospitals' total volume and the costs to treat those patients was over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. The Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. They have historically been the only clinics that were available on an open door policy for pregnant women and children services regardless of the ability to pay. An addition of a primary care clinic provides another source for referrals. Currently, those clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances Hospitals and Clinics. Trinity Clinic has a 11% Medicaid and self pay percentage.

Why telephonic access to pediatric consultations? The pilot program offers an opportunity for patients and their families to remain in their communities while still receiving the medically-appropriate level of care. Expanding the capacity of local providers to care for medically complex children through telemedicine will positively affect pediatric patient care and can lower associated costs in the region. The expected result will be decreased cost of care for children by preventing unnecessary emergency room visits, and unnecessary patient transfers for those conditions that can be managed locally or in a less acute setting.

Mother Frances Hospital and the emergency department is the place most of the pediatric care is given in the area. Having access to specialists and subspecialists will allow the best recommendations and care plans to be developed for the patient in the most cost effective manner.

Mother Frances Hospital also leads the region for Medicaid births and pediatric services for Medicaid mothers and babies. Having access to higher level of care telephonically and through telemedicine will impact the families throughout the region. Babies are transferred to MFH from the region for a higher level of care.

Additionally, with access to a larger group of specialist more pediatric patients will be able to remain in the local hospital rather than be transferred. This reduces days off of work for the families, allowing a local family support group to be closer, enhances the ability of the family to stay on the job rather than traveling 100 miles daily or incurring the costs of staying away from home.

As of July 2013, Trinity Clinic will no longer have a geneticist as part of the clinic and no positive recruits are in the pipeline to fill that vacancy. It is imperative that access to a pediatric geneticist be made available through the use of telemedicine with the number of high risk pregnancies and births that are a part of the Mother Frances Hospital fabric.

Goals and Relationship to Regional Goals: The goals of this project are to increase the availability of pediatric specialty care services in the region and ease the gaps in providing crucial care to children who are underserved, principally because of a shortage of specialty providers and a shortage of such providers who accept Medicaid or CHIP. Engaging in

educational initiatives and utilizing telehealth to link primary care providers with pediatric specialists will ensure both the availability and use of cost-effective, high-quality pediatric care, and reduce unnecessary use of emergency department services and transfer of patients.

This project meets the following Region 1 goals:

- For the purpose of this project Trinity Mother Frances Healthcare System will *implement ways to expand the pediatric specialty and subspecialty care by:* Expand and enhance the capacity of providers in the region to manage complex pediatric patients locally through timely access to pediatric specialists via telephonic consultation. Eligible providers will have access to education services and a single-access phone number allowing the local provider to connect with the desired specialist and subspecialist.

- *The ultimate benefit of these initiatives is (1) to reduce the* need to transfer patients to Dallas for consult, (2) providing those consults in a more timely manner, (3) providing education for the providers and their staff on how to maximize usage of this new service thus lowering the cost of care, and (4) using a common new electronic medical record system, EPIC, which no other health system in the region has implemented and Children's Medical Center is using, to maximize the transfer of information to better serve our pediatric patients and their families.

- Using the new electronic medical record system, EPIC, which no other health system in the region has implemented, allows all providers in the system, including hospitals, to see the status of the patients care immediately. And, the patient is able to review his medical records and seek information directly with the provider without having to seek care in a traditional clinic setting. These features should help relieve overcrowding at some level and provide patients with critical information directly.

Challenges: With almost 80% of specialty pediatric care leaving the area because of the lack of providers, this project allows for patients to be seen locally and in a more cost effective and efficient manner. Our direct care centers are overrun on the weekends and after hours with pediatric patients who may need a higher level of care. Pediatric patients who are sent to the emergency department and who currently need to be flown to Dallas for care will now be able to have access to a specialist through the telehealth program.

The pediatricians and emergency department providers and staff have not used telehealth prior to this project and will require training and education on the opportunities as will their families they care for everyday. The uniqueness of this new opportunity for our pediatric patients and providers is clearly one of the key reasons this is a pilot project just for ED. It is anticipated that as the providers use this new service, the demand will be to expand it to all the urgent care centers and pediatric offices.

The other key user group will be our NICU providers. The NICU is staffed by three (3) neonatologists and two (2) advance nurse practitioners. Having this new telehealth project will allow for immediate consults regardless of the time of day that will lower the number of

transfers to Dallas to simply have a consult with a provider. These are high cost patients and the consult and transfer are very high additional expenses that can be lowered by not having to transfer for a consult.

Five-Year Outcomes: The minimum expected five-year outcomes for this project are to increase access for pediatric specialty care, improve the wait time for consults with pediatric specialists for inpatient care, and to establish an opportunity for training for Mother Frances Hospital staff and providers and for the residents who train at Children's to better understand the needs of rural areas. The improvement in access for pediatric patients through the pilot pediatric specialty telehealth project will result in extended hours of access and more pediatric specialty providers of services, all of which will impact low income, CHIP, and Medicaid patients. It is essential to expand the pediatric specialist providers to address the need for the right care at the time to be offered for our young patients and to improve quality outcome measures especially for the ED.

Starting Point/Baseline: The starting point/baseline for the primary care expansion initiative will be the implementation date of the Medicaid Waiver project: September 30, 2012. This is a new program thus our base line is zero and patients served through telehealth is zero.

Rationale: The counties included in RHP #1 have 32 hospitals and a pediatric population of more than 317,000 — but no free-standing children's hospital. Emergency departments are treating high volumes of pediatric patients with conditions that are suitable to be addressed in a less acute setting given the right support.

A number of studies have been done to determine if specialty care could be provided by hiring providers instead of sending patients to the metroplex. Unfortunately, until the region grows or the region establishes a central location for pediatric care, there simply are not enough patients to fill a full time practice or to have a pediatric specialist on site one day a month or every other week. Yet, when the care or consult is needed this pilot project for telehealth will provide that care. This pilot project seeks to provide the care on an immediate basis with highly qualified providers whose skill set will be high quality and update yet at a reasonable cost to families.

Children's Medical Center of Dallas received 10,683 unique patient visitors from the counties included in RHP#1 in 2011, representing more than 31,000 patient interactions. In addition, over the past 12 months, the Children's Medical Center's Access Center has coordinated transfers for 143 patients from the facilities located within RHP #1 and completed 48 transports using the Children's Transport Team. If a pediatric subspecialist was available, a percentage of these patients could have been cared for locally and a percentage could have been more quickly assessed to determine if a need to transfer to a higher level of care was appropriate.

The proposed program already has a track record of success in the areas where it has been implemented. In just under one year and from other regions of the state, Children's Medical Center has received and completed 313 telephonic consultations enabling providers to care for

their pediatric patients locally and, in many cases, without the need to escalate the level of care. Current volumes are absent any marketing or promotion efforts, indicating an opportunity to further extend the expertise of our subspecialists and specialists to additional providers, an increase in demand that Children's and its providers are prepared to meet. The program is designed to provide access to all providers, whether rural or urban, independent or hospital-based.

In an effort to reduce barriers to care and increase much-needed access to pediatric specialty care for patients in our service areas, this new initiative with Children's Medical Center and Trinity Clinic Pediatrics, Tyler Family Circle of Care, the neonatologist, and the emergency room physicians is an effort to improve access and quality of care.

Children's Hospital in Dallas will be providing the pediatric specialists, education for using telemedicine for providers and clinical staff in all areas using the service, staff education for IT services, support for IT systems as needed, consulting services for selection of equipment, and information to use for patient and family education as needed. This collaboration is new to RHP#1 and will be providing a new source of access for patient and their families. We anticipate this will be a program that has the opportunity to grow and be used by others across the state as a way to provide enhanced services for pediatric care.

Project Components:

The goal of this project is to implement telemedicine program or expand specialist referral services in an area identified as needed to the region. All required core project components will be addressed in this project:

a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications

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

Milestones: P-1, P-2, P-3, P-6, P-11 (DY 3 & 4), I-12, I-17

Metrics: p-1.1, p-2.1, P-3.1, P-3.2, P-6, P-11.1 (DY 3 & 4), P-11.2 (DY 3 & 4), I—12.1, I-12.2, I-17.1

The metric selected address the core components and will be addressed by a multiuser workgroup with representatives from MFH and Children's Medical Center.

Community Needs: CN.1, insufficient access to primary and specialty health care services, CN.5, inappropriate emergency department utilization, and CN.6 efficiency in and effectiveness of health care delivery.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Currently there are few pediatric specialists in Region 1 and no subspecialist. There are a few specialists who come out monthly and sometimes bi-monthly to provide care. Those services do not meet the needs of the emergency room or the inpatient

care that require consults. It is a burden for the patient's family to travel, a quality issue for the patients and physicians, and a service that should be provided to children in an emergency room setting. This will also enhance outpatient services for the pediatric physicians.

Related Category 3 Outcomes Measure: Providing pediatric specialty care via telemedicine will improve the quality of care of young patients and their families. To demonstrate this, Trinity Mother Frances Hospitals and Clinics have selected the related category 3 Outcome Measure: OD-9 Right Care, Right Setting. IT-9.2 ED appropriate utilization. (Stand alone measure)

Rationale for selecting the outcome measure: This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children as well as all children. Nearly 80% of the pediatric specialty care must be found 90 miles outside of the largest city in Region 1. The distance is further from many areas of the region. Hospitals and physicians are currently left with no choice but to air flight a patient to Dallas for a consult. This is costly to both the providers and the families and is not the quality of care expected.

Relationship to Other Projects and Measures: All of the projects of Mother Frances Hospital complement each other to meet the transformational goals and the three aims of CMS. As Donald Berwick said in Health Affairs, "Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations." We agree and fully support that through our projects for this program: Expand Primary Care, Expand Specialty Care, Patient Navigator, Pediatric Specialty Care through telehealth, and Cost Containment.

The development of telehealth for pediatric specialty care will have a regional and system wide impact and will support and reinforce other DSRIP projects. Improved access to pediatric specialty care in the emergency room and for outpatient consults results in improved patient outcomes. Both Children's Medical Center and Mother Frances Hospital and Trinity Clinic are all on EPIC for electronic transfer of information and medical records.

Relationship to Other Performing Projects in the RHP1: Increasing telehealth is a major initiative of the entire region. Many of the other regional partners have selected this type of project but none have focused on pediatric specialty care. It is our full intention to participate and lead, if asked, some of the learning collaborative opportunities to share best practices.

Currently, Trinity Clinic and Mother Frances Hospital are the only facilities that have large pediatric practices including large special needs clinics, Level III NCQA certified Primary Care Medical Homes including pediatrics, a NICU, and an emergency department that is thought of as the pediatric ED. A number of other health care facilities are hoping to achieve this and we feel we will be a strong asset for this process in the region. Expansion of telemedicine for pediatrics is very important to other facilities and partners in the regions.

Plan for Learning Collaboratives: Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. Mother Frances Hospitals participates in several learning collaboratives with other hospitals including Health Care Coalition of Texas (hospitals across Texas- all not-for profit) and Texas Coalition for Access which includes Baylor, and Scott and White. MFH believes in and supports the value of learning collaboratives. MFH will support the plans of Region 1.

The system pledges to develop, support, and participate in the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to participate and share information in the collaboratives and to inform others of our experiences and best practices acquired and learn from others in the state. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, Titus Regional, and MFH, have met to discuss the project planning process and selection of projects.

Project Valuation: The value of this project is based on the broad impact that additional pediatric specialists providers would have on the identified community needs. Increasing the number of pediatric specialists directly improves the shortage of providers in the community and lessens the need to travel 100 miles for care–It is extremely unlikely that pediatric subspecialists and specialists will find the growth in east Texas large enough to sustain the financial burden of recruitment and practice development. Consequently, maximizing the opportunity to introduce telemedicine to east Texas for pediatric support is critical for patient care. Having immediate access to a specialist is best practice for all age group but can be especially critical for pediatric services. NICU babies all too often must receive specialized care and having the ability to engage in telecommunication consults is a much more effective, immediate and cost effective manner in which to provide that high level of care. An additional value of this program is the education that all providers of pediatric patients will receive by participating in these calls. As more ED providers use this service, the more comfortable they will become at determining who needs to be transferred to a children's hospital and who can receive appropriate care at the local hospital. The lessons learned and skills enhanced will be shared with other facilities as part of our "raising the floor" initiatives and learning collaborative. Thus the entire region will benefit and not just Mother Frances Hospital.
While nearly 50% of the patients seeking care are estimated to be Medicaid or Indigent, those families are the less likely to have resources to sustain care if they have to travel outside of their local area or be able to be at a metropolitan facility. Studies show that without the support of the mother of the child, the length of stay is longer and positive outcomes are not as good.

References

- Halfon N, Newacheck PW, Wood DL, St Peter, RF., "Routine emergency department use for sick child care by children in the United States ." *Pediatrics.* 1996; 98: 28-34
- Smith-Campbell B., "Emergency department and community health center visits and costs in an uninsured population." *Journal of Nursing Scholarship.* 2005; 37(1): 80-86

- Cooley WC, McAllister JW, Sherrieb K, Kuhlthau K., "Improved Outcomes with Medical Home Implementation in Pediatric Primary Care." *Pediatrics.* 2009; 124: 358-364
- Flores G., "The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review," *Medical Care Resources Review.* **June 2005;** 62: **255-299**

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Trinity Clinic and ContinueCARE Hospital. By working as a health care system the impact on recruitment and access to providers is made possible for not only access to pediatric telemedicine services in the ED but also to improve care transitions and provide patient navigation services. Again, these programs will impact patient care across the RHP#1 and access for both inpatient and outpatient services.

Additionally, the impact of the cost savings projects will make a significant impact on these two entities also, even though their funding was not directly applied to that project. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformable project be available to the rural hospitals and out-patient services.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

094108002.1.3	1.7.1	1.7.1, A,B	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.4	IT-9.2	ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1: Conduct a needs assessment to identify needed specialties that can be provided via telemedicine. Metric 1 P-1.1: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel. Baseline: No Assessment Goal: Complete needs assessment. Data source: Needs assessment. **Milestone 1 Estimated Incentive Payment: $425,820**	**Milestone 3 P-3:** Implement or expand telehealth program for selected medical specialties, based upon regional and community need. Metric 1 P-3.1: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Baseline: Plan developed DY2 Goal: Plan implemented Data source: Program materials. Metric 2 P-3.2:	**Milestone 6 P-11:** Participate in face-to-face learning at least twice per year with other providers in the RHP to promote collaborative learning around similar or shared projects. Metric 1 P-11.1: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: Participated DY2 Goal: Meetings attended, initiatives implemented. Data source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.	**Milestone 8 I-12:** Increase number of telemedicine visits for each specialty identified as high need including telephone consultations. Metric 1 I-12.1: Number of telemedicine visits. Baseline: New visits 0 Goal: 250 telemedicine patient visits; documentation provided. **Milestone 8 Estimated Incentive Payment: $807,968**

094108002.1.3	1.7.1	1.7.1, A,B	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.4	IT-9.2	ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 P-2: Conduct a needs assessment to identify needed services that could be delivered via telehealth. Metric 2 P-2.1: Needs assessment. Baseline: No Assessment Goal: Needs assessment completed Data source: Needs Assessment. **Milestone 2 Estimated Incentive Payment: $425,821**	Documentation of the number of consults delivered by each specialty. Baseline:0- New service Goal: 175 telemedicine patient consults. Data source: Clinic log of health services by telemedicine service. **Milestone 3 Estimated Incentive Payment: $316,811** **Milestone 4 P-6:** Implement or expand medical education and specialized training programs via telehealth program. Metric 1 P-6.1: Submission		Metric 2 P-11.2: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: Participated DY2 Goal: Meetings attended, initiatives implemented. Data source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. **Milestone 6 Estimated**	

094108002.1.3	1.7.1	1.7.1, A,B	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.4	IT-9.2	ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	and number of distinct curriculums delivered. Baseline:0- No training Goal: Program implemented. Data source: Program materials. Metric 2 P-6.2: Number of trainees attending via telehealth. Baseline:0-No trainee's Goal: Trainee's implemented. Data source: Submission of program registration documents. **Milestone 4 Estimated Incentive Payment: $316,811**		**Incentive Payment: $485,552** **Milestone 7 I-12:** Increase number of telemedicine visits for each specialty identified as high need including telephone consultations. Metric 1 I-12.1: Number of telemedicine visits. Baseline: 0 – new visits Goal: 225 patient visits Data source: EHR or electronic referral processing system; encounter records from telemedicine program Metric 2 I-12.2: RHPs and providers should provide analysis demonstrating how the telehealth services	

094108002.1.3	1.7.1	1.7.1, A,B	Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.4	IT-9.2	ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5 P-11: Participate in face-to-face learning at least twice per year with other providers in the RHP to promote collaborative learning around similar or shared projects. Metric 1 P-11.1: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: 0- new program Goal: Meetings attended, initiatives implemented Data source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.		provided align with their needs assessment. Baseline: 0- new program Goal: Needs assessment completed and review reported Data source: List of Needs Assessment prioritized by year **Milestone 7 Estimated Incentive Payment: $485,552**	

094108002.1.3	**1.7.1**	**1.7.1, A,B**	**Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region**	
Mother Frances Hospital				**094108002**
Related Category 3 Outcome Measure(s):	**094108002.3.4**	**IT-9.2**	**ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 2 P-11.2: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: No initiatives Goal: Meetings attended, initiatives implemented Data source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. **Milestone 5 Estimated**			

094108002.1.3	**1.7.1**	**1.7.1, A,B**	**Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region**	
Mother Frances Hospital				**094108002**
Related Category 3 Outcome Measure(s):	**094108002.3.4**	**IT-9.2**	**ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Incentive Payment: $316,811			
Year 2 Estimated Milestone Bundle Amount: **$851,641**	Year 3 Estimated Milestone Bundle Amount: **$950,433**		Year 4 Estimated Milestone Bundle Amount: **$971,104**	Year 5 Estimated Milestone Bundle Amount: **$807,968**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: **$3,581,145**				

Project Option: 1.1.2 – Expand existing primary care capacity
Unique Project ID Number: 094127002.1.1
Performing Provider Name/TPI: ETMC Carthage 094127002

Project Abstract

Provider: East Texas Medical Center Carthage (ETMC) is a 49-bed, full-service hospital dedicated to serving the Panola County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Panola County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 242,000.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, recruiting a family practice physician and a physician assistant, and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Southeastern Region (Cherokee, Gregg, Panola, and Rusk Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 3,165 new clinic patients with a Medicaid and indigent share of at least 30%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and recruiting a family practice physician and a physician assistant. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include a family practice physician, a physician assistant, and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services and pediatrics. The ETMC Southeastern Region is currently underserved by 36 primary care physicians—including a shortage of 3 family practice physicians.

Service Area Population 242,017							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7		29.5	71	68	(3)
Geriatric Medicine	0	0	2.6	2.6	6	4	(3)
Internal Medicine	28.8	17.6		23.2	56	36	(20)
Pediatrics	12.8	12.9		12.9	31	20	(11)
Primary Care Total					**165**	**128**	**(36)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 36,768 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC's ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care

expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends and recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours and clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (094127002.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (094127002.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (094127002.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

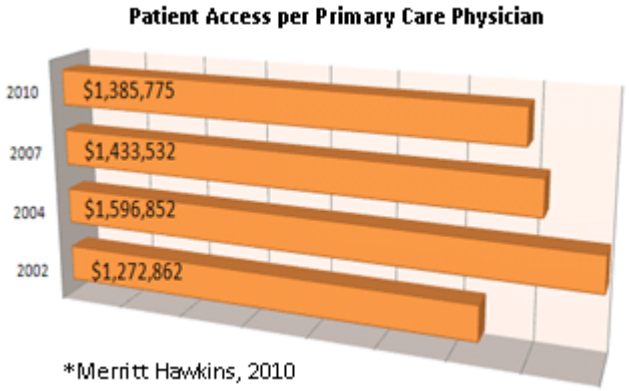
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

Applying the decreased utilization data values the savings at $.8M and the physician impact on access is valued at $1.3M. Accordingly, ETMC's average DSRIP funding request of approximately $.5M per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		3,165
ED visits / year / person		0.45
Potential ED Visits		1,427
ED Visits Reduced @ 15%		214
Avg ED Payment		$425
ED Savings	**$**	**90,987**
IP Admissions / year / person		0.11
Potential IP Admissions		361
Admissions Reduced @ 18%		65
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**801,961**
Total Estimated Savings	**$**	**892,948**



094127002.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Carthage			*094127002*
Related Category 3 Outcome Measure(s):	***094127002.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline. **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $369,029	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 5% over baseline of 36,768 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $402,591	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 10% over baseline of 36,768 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $403,761	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 15% over baseline of 36,768 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $333,542
Year 2 Estimated Total DSRIP: $369,029	Year 3 Estimated Total DSRIP: $402,591	Year 4 Estimated Total DSRIP: $403,761	Year 5 Estimated Total DSRIP: $333,542
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,508,923***			

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 094190802.1.1 (Pass 1)
Performing Provider Name/TPI: ETMC Fairfield 094190802

Project Abstract

Provider: East Texas Medical Center Fairfield (ETMC) is a 48-bed, full-service hospital dedicated to serving the Freestone County area with advanced diagnostics, medical and surgical care, and outpatient services. ETMC's primary service area is Freestone County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 258,782.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends and adding needed physician and support hours.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Western Region (Freestone, Henderson, Kaufman, and Van Zandt Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 914 new clinic patients with a Medicaid and indigent share of at least 25%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 8% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and staffing. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by an 8% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions

are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include additional physician hours as well as needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 17,834 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal,

suggests that “two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent).”

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It’s Not At Their Doctor’s Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC’s ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and clinic staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (094190802.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and staffing (094190802.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (094190802.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

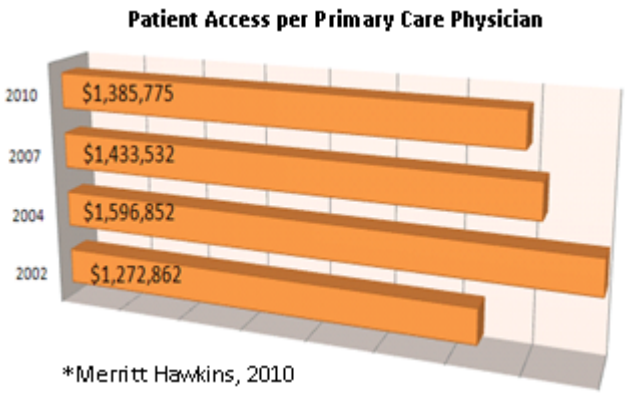
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $257,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $136,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		914
ED visits / year / person		0.45
Potential ED Visits		412
ED Visits Reduced @ 15%		62
Avg ED Payment		$425
ED Savings	**$**	**26,278**
IP Admissions / year / person		0.11
Potential IP Admissions		104
Admissions Reduced @ 18%		19
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**231,614**
Total Estimated Savings	**$**	**257,892**



094190802.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Fairfield			*094190802*
Related Category 3 Outcome Measure(s):	***094190802.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $107,564	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 4% over baseline of 17,834 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $117,347	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 6% over baseline of 17,834 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $117,688	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 8% over baseline of 17,834 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $97,220
Year 2 Estimated Total DSRIP: $107,564	Year 3 Estimated Total DSRIP: $117,347	Year 4 Estimated Total DSRIP: $117,688	Year 5 Estimated Total DSRIP: $97,220
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$439,819***			

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 121817401.1.1 (Pass 1)
Performing Provider Name/TPI: ETMC Trinity 121817401

Project Abstract

Provider: East Texas Medical Center Trinity (ETMC) is a 30-bed, full-service hospital dedicated to serving the Trinity County area with advanced diagnostics, medical and surgical care, outpatient services, and a Level IV trauma center. ETMC's primary service area is Trinity County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 94,915.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, recruiting a family practice physician, and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Southern Region (Anderson, Houston, and Trinity Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 2,102 new clinic patients with a Medicaid and indigent share of at least 35%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and recruiting a family practice physician. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions

are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include a family practice physician and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services and pediatrics. The ETMC Southern Region is currently underserved by 23 primary care physicians—including a shortage of 5 family practice physicians.

Service Area Population 94,915							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7		29.5	28	23	(5)
Geriatric Medicine	0	0	2.6	2.6	2	3	1
Internal Medicine	28.8	17.6		23.2	22	11	(11)
Pediatrics	12.8	12.9		12.9	12	5	(7)
Primary Care Total					**65**	**42**	**(23)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current

physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 18,252 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC's ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends and recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours and clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (121817401.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (121817401.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (121817401.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

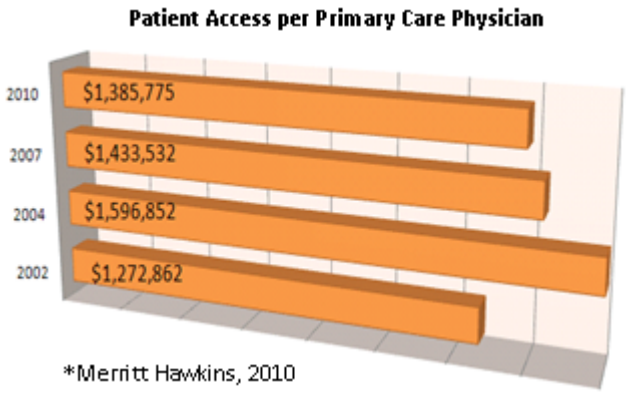
Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data

on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $593,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $527,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		2,102
ED visits / year / person*		0.45
Potential ED Visits		948
ED Visits Reduced @ 15%		142
Avg ED Payment		$425
ED Savings	**$**	**60,429**
IP Admissions / year / person*		0.11
Potential IP Admissions		240
Admissions Reduced @ 18%		43
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**532,625**
Total Estimated Savings	**$**	**593,055**



121817401.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Trinity			*121817401*
Related Category 3 Outcome Measure(s):	***121817401.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline. **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $415,376	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 5% over baseline of 18,252 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $453,153	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 10% over baseline of 18,252 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $454,470	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 15% over baseline of 18,252 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $375,432
Year 2 Estimated Total DSRIP: $415,376	Year 3 Estimated Total DSRIP: $453,153	Year 4 Estimated Total DSRIP: $454,470	Year 5 Estimated Total DSRIP: $375,432
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,698,431***			

Project Option: 1.12.2 – Expand number of community based settings where behavioral health services may be delivered in underserved areas.
Unique Project ID Number: 121988304.1.1
Performing Provider Name/TPI: Lakes Regional MHMR Center 121988304

Project Abstract

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

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

Intervention(s): This project will create three clinics new in RHP 1 for provision of evidence-based services for individuals who suffer from depression or trauma related disorders not meeting the state mandated diagnostic criteria for eligibility for state funded behavioral health services primarily residing in counties near the cities of Paris, Sulphur Springs and Mt. Pleasant in RHP 1. This project intervention is new; there is no such clinic in the area oriented to the targeted population of low income and Medicaid recipients in the proposed service area.

Need for the project: There are currently no services available for low income and Medicaid populations defined above who have diagnosable symptoms or a behavioral health crisis other than reporting to the hospital emergency department or driving a prohibitive distance. The affected counties are in need of a source for referral from hospital, physicians and public servants for access to services for the target population (low income or Medicaid eligible of eight rural counties) that are not cost prohibitive. The project will improve access ~~to access~~ to behavioral health care and overall quality of health care for the targeted safety net population, and lower the cost of care by decreasing demand on Emergency Department services.

Target population: The target population is a minimum of 297 ~~260 to 300~~ citizens over the course of the Waiver needing access to depression or trauma related behavioral health services that are without alternative providers (i.e., high cost private providers or state funded services restricted to Major Depression, Bipolar, Schizo-Affective, or Schizophrenic disorders).

Category 1 or 2 expected patient benefits: The project seeks to provide access to screening, referral and therapeutic services in individual, family and groups which are evidence-based leading to recovery and increased quality of life, satisfaction with care, reduced likelihood for need of higher level of care and avoidance of emergent or intervention services.

Category 3 outcomes: IT-10.1 Quality of Life

The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. To demonstrate improvement in symptoms and function, the quality of life (SF-36) validated assessment tool will be implemented to measure improvement in quality of life mental and physical functioning factors. The projected ~~aggregate~~ improvement ~~percentage~~ is to achieve and maintain a mean 10% for the growing aggregate population through the waiver period ~~DY4 and continuing for DY 5~~. Minimum unique participants per year will be: DY-3=190, DY-4=228 and DY-5=297; totaling 715.

Project Narrative

Project Description: Rural communities are underserved in behavioral health (Hogg Foundation, 2010). This is true of the several counties served by Lakes Regional MHMR Center (LRMHMRC) in northeastern Texas in RHP 1. Mental Health (MH) outpatient and crisis services are provided in those areas through LRMHMRC clinics primarily in three cities. The National Association of State Mental Health Program Directors estimated that states have cut $3.4 billion in mental health funding since FY 2009, while the demand for services has increased during this time period (since FY 2009, demand for community-based services has increased by 56 percent, and the demand for emergency room (ER), state hospital, and emergency psychiatric care has climbed 18 percent) (Womble, N., 2012). In Texas, state funding for behavioral health is prioritized to a narrow set of diagnostic and severity criteria. ~~These services are provided under specific requirements and are not available to many in need of behavioral health care. Individuals being served by the state behavioral health system for severe depression become stable and appoint for access to medication continuation. They often schedule but do not attend other services required for enrolled clients by state mandate which they no longer desire. Recent numbers at the three (3) LRMHMRC clinics revealed 590 failed appointments in one month out of the total 1,403 clinic population (42%) thus reducing resource access to others. These stable clients without access to alternative prescriber affiliation and no longer requiring the State mandated services need an appropriate prescriber resource to access for continued care making room for others and reducing waste.~~ Likewise, others in the community who do not meet the state criteria for supported services other than the local hospital emergency department (ED) need an appropriate place to obtain effective depression and trauma services to lower the overall cost of health care in the county by providing the proper care in the proper context. ~~need access to less intensive outpatient behavioral health care~~.

LRMHMRC will develop and establish three behavioral health Depression/Trauma Counseling Centers for individuals with a primary need for mental health screening and treatment for symptoms of depression and mental anguish or trauma. Members of the community similarly affected who do not meet State criteria for Serious Mental Illness (SMI) services will be able to access the appropriate level of service without engaging the local hospital Emergency Department (ED). The Screening – Brief Intervention Referral and Treatment (S-BIRT) evidence-based tools to screen and intervene for substance abuse will be used. Screening services will be able to identify and link clients who present with co-morbid substance use disorders for proper treatment. The project will allow stable individuals currently receiving service in the behavioral health system to continue access to prescription service and appropriate therapeutic services. Evidence-based individual and group counseling services will be rendered by personnel prepared specifically for Depression and Trauma screening and interventions. ~~Clients with the need for prescription and monitoring of depression medications by an appropriate prescriber will have it available through another waiver project~~.

Describe the project Goals: The goal for the citizens not eligible for State supported behavioral health services due to diagnostic restrictions is to have an available clinic to provide evidence-based screening and/or treatment services for the array of depression, substance abuse and trauma related anxiety concerns. ~~Secondly, the goal for stable SMI clients of the mental health clinics that need only prescription services (currently estimated at 240) is a service that meets their need at the appropriate unencumbered level of care and allows them to close services at the mental health clinic making greater (CN.6) Efficiency in and effectiveness of health care delivery for higher level of care services available for others~~. Greater satisfaction with appropriate and effective services is a goal for both groups. The goal for the community and the region is the expansion of behavioral health clinics and services appropriate services in the right place to

populations who do not presently have access to these resources and the resultant alleviation of inappropriate burden on hospital emergency departments and other community resources.

Describe any challenges or issues: Access to state supported mental health services is restricted to those individuals with SMI and the service array narrow in scope around the restricted diagnostic criteria. Members of the broader community in mental and emotional distress due to symptoms related to moderate depression or trauma and who do not have financial resources for private care seek relief assistance through the ED at local hospitals increasing the overall cost of services to the community. Local hospitals seek a solution to the pressure on the ED to serve what are regarded as psychologically related symptom driven presentations. There is no apparent mental health trauma treatment available to indigent or Medicaid populations in this RHP area as an alternative to the current pattern of Emergency Room (ER) usage. RHP 1 has recognized the dearth of MH service in the communities-at-large via the Community Needs Assessment as (CN.2) Insufficient access to mental and behavioral health services. This contributes to (CN.5) Inappropriate emergency department utilization and (CN.4) High costs due to potentially preventable hospitalizations.

The 5-year expected outcome: The five year expected outcome of the project is three new clinic resources in three dominate cities in rural underserved counties providing outpatient evidence-based screening, counseling and ~~prescription~~ group services to at least 715 community members thereby contributing to the overall health delivery system through appropriately and effectively addressing mental health concerns which at present contribute to inefficiencies, possibly preventable hospitalizations and inappropriate ED utilization increasing the cost of health care in the community. ~~LRMHMRC will be able to service in present clinics more efficiently and effectively those needing the higher level of stabilization and recovery care and make an impact on the MH needs of the larger community.~~ Services will start in DY3 with a minimum unique participant objective of 190 in that year. A 20% increase in DY4 of 228 new unique participants. A 30% increase in DY5 over DY4 will result in 297 unique new participants seen during that year; thus a 715 minimum clientele served over the course of the waiver. Individuals served in both levels of clinics will experience a greater level of satisfaction and improved personal efficacy from their state of entry into services. They will have measureable improvement in their quality of life from program participation.

Describe how the project is related to regional goals: The project relates to the Region 1 goal to improve access to behavioral health services and to reduce the unnecessary use of Emergency Department services (CN.2, CN.5) by providing new behavioral services as an alternative to the use of higher levels of care.

Starting Point/Baseline: While the local hospital personnel in the communities served by LRMHMRC rural mental health clinics have urged the development of a referral resource for their ED patients that present with behavioral health driven complaints, no such low cost solution exists in any of the communities. The program will have to be developed from the point of researching all aspects and creating an operational plan: community resources, selection parameters, protocols, evidence-based programming choices, location, hiring and training qualified staff. However, LRMHMRC is well familiar with the communities and will be able to extend the services of the Information Technology (IT) and business departments to support accounting, reporting, quality improvement, electronic medical records and telemedicine or mobile health clinic to cover prescriber service access. Following these DY-2 preparations and staffing selections, provider competence in the chosen intervention models will be trained and services initiated in DY-3. Continuous improvement strategies will guide the refinement of operations and services from DY-3 through DY-5. LRMHMRC will seek to collaborate with Primary Care providers for more integration of care where possible.

Rationale: Rural communities need adequately trained resources to respond to the demand for care for trauma recovery and depression for populations where those services do not currently exist. Lakes Regional chose this project category and option due to the restrictions in state budgeted mental health services and the obvious access needs of the un-served populations in the counties. Ratios of mental health service providers to populations in the counties range from 1:9,792 up to 1:17,073 and State Department of Health figures also show regional estimates of 85,000 individuals with SMI and over 100,000 needing substance abuse treatment (CNA above). The vast majority of patients with behavioral health problems go without care, visit the ER in emotional/somatic crisis or visit primary care providers without behavioral health specialty care, either because the individual in need doesn't meet entry criteria into the mental health system (generally limited to the severely mentally ill) or because the individual refuses behavioral health specialty care due to the stigma attached, the requirements of the State services viewed as cumbersome or care is too costly. Adults with mental illnesses were more likely to use an ER or be hospitalized in the past year (at least one visit) than adults without mental illnesses. Compared with adults without mental illness, adults with SMI were more likely to use an ER (38.8 vs. 27.1 percent) in the past year and to be hospitalized (15.1 vs. 10.1 percent) (The Substance Abuse and Mental Health Services Administration SAMHSA, 2012).

Reason(s) for selecting the project: Having a clinic in the community available with trained personnel in appropriate service delivery for these concerns will be a new addition to overall community health resources. Many primary care providers feel poorly equipped to handle significant behavioral health issues by themselves. "The impact of psychological interventions on the use of medical services was evaluated by examining the outcome of 91 studies published between 1967 and 1997 using meta-analytic techniques and percentage estimates. Results provided evidence for a medical cost-offset effect, specifically in the domain of behavioral medicine. Average savings resulting from implementing psychological interventions was estimated to be about 20%. About one third of the articles demonstrated that dollar savings continued to be substantial even when the cost of providing the psychological intervention was subtracted from the savings." (Chiles, J. et.al., 1999).

~~LRMHMRC currently serves at least 240 individuals (17%) among the rural clinics that receive only medication prescription services for their depressive symptoms and are not interested in other required services under State protocols for enrolled clients accounting for a large portion of serial failed appointments and wasted professional man hours. Treatment in this type of clinic will allow greater satisfaction with the level of care desired by clients, and the existing SMI clinics to better serve individuals in need of more intense services.~~

Reasons for selecting the milestones and metrics: The milestones and metrics chosen for the introduction of new clinics serving a niche unavailable in the current health delivery system are in keeping with the Community Needs Assessment item "CN.2 Insufficient access to mental and behavioral services". Category 1.12, Option 1.12.2. "Expand the number of community based settings where behavioral health services" seemed the most descriptive menu item for the project. Thus the milestones chosen to inform and prepare the project are P-3. Process Milestone: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for a transportation program)., P-4. Process Milestone: Hire and train staff to operate and manage projects selected and P-6. Process Milestone: Establish behavioral health services in new community-based settings in underserved areas. Once services are initiated, the milestone to expand the community presence and access will be I-11 Improvement Milestone: Increased utilization of community behavioral healthcare and the impact on the participant's milestone will be I-14 Improvement Milestone: Improved Consumer satisfaction with Access.

Specify the unique community need identification number the project addresses: Community Need Identification Numbers:

(CN.2) Insufficient access to mental / behavioral health care services.
(CN.4) High costs due to potentially preventable hospital admissions / readmissions.
(CN.5) Inappropriate emergency department utilization.
(CN.6) Efficiency in and effectiveness of health care delivery.

Describe how the project represents a new initiative or significantly enhances an existing delivery system reform: The Depression/Trauma Clinic provides a needed level of care in the continuum of health care in the communities filling an important gap in behavioral health care. It is in keeping with the delivery reform initiative in providing the right care in the right place leading to system efficiencies and cost reductions. The project is not related to any other known U.S. Department of Health and Human Services initiatives.

Related Category 3 Outcome Measure(s): Lakes Regional chose the outcome domain OD-10 Quality of Life/ Functional Status and the Improvement target IT-10.1 Quality of Life because an individual's experience of increasing personal efficacy is central to their recovery from psychologically related impairment. It ferments hope and commitment to a course of treatment realizing positive gains. It is perhaps the most important metric in a person deciding to engage in treatment at the low end, whether to continue, and when they have achieved their internal goals, restoration, and/or well-being enough end with a successful experience. The impact of successful behavioral health treatment on cost containment, positive outcomes, and reduction of hospital usage in health care is well established and consistent with the goals of the transformation waiver and the RHP 1. Access to new and appropriate level behavioral health services adds needed mental health providers to the area underscored by the data in the Community Needs Assessment (CAN) in this document. Effectively provided it will lead to personal improvements that will register on a validated Quality of Life instrument measuring both physical and mental functioning such as the SF-36 (Protocol, pg. 406) and will act to inform and validate the project across participants. It perhaps more importantly will serve to acquaint individual participants with a standard measure of their internal recognition of progress reinforcing a sense of accomplishment. This access to service and outcome focus will provide external and internal evidence to improvement and appropriate use of health care resources by low income populations in the communities.

Relationship to other Projects: 121988304.2.1, Lakes Regional Integrated Care Project. Within RHP 1, this Category 2 project of Integrated Primary and Behavioral Health Care will provide Primary and Behavioral Health Care Services and include Medical Clinic, LRMHMRC (121988304) to individuals with SMI enrolled in existing clinics and be a medical underpinning to their treatment with attention to co-occurring physical health difficulties for improved overall outcome. ~~The Mobile Medical Clinic only will provide prescription services to the Depression/Trauma Clinics allowing appropriate medication support for patrons and the ability for stable individuals ready to discharge from the existing MH clinics to have ongoing prescriptive services.~~

Describe the related Category 4 Population-focused improvements with the unique RHP project identification number based on the requirements above: (N/A)

Relationship to Other Performing Providers' Projects in the RHP: A few other providers are proposing similar projects hopefully reducing hospital emergency department use for behavioral crisis but are doing so in other counties within the region. The target group for these other projects does not overlap with the area served by LRMHMRC. However, LRMHMRC will seek to share experiences in approach and lessons learned within the region toward discovering best practices.

Plan for Learning Collaborative: The region has intentions of developing a learning collaborative stating, "As the region's providers implement improvements, it is important that they learn from each other's successes and challenges, as well as identify best practices that can be widely replicated." LRMHMRC is aligned with this sentiment and supportive of the regional efforts. To this end, Region 1 will develop learning collaboratives that focus on: Sharing knowledge, experience and expertise; improving patient and caregiver experience; implementing evidence-based guidelines; using data-driven analyses to drive performance improvement; and Testing, such as through Plan-Do-Study-Act (PDSA) cycles.

Project Valuation: Rural communities need adequately trained resources to respond to the demand for care for trauma recovery and depression for populations where those services do not currently exist. Lakes Regional chose this project category and option due to the restrictions in state budgeted mental health services and the obvious access needs of the un-served populations in the counties The scope of this project could impact a potential of at least ~~260 300~~ 715 patients in a largely rural medically underserved geographic area. This project was valued based upon three valuation research studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research:

- *Valuing the Program to Expand Behavioral Health Outpatient Capacity (ATCIC) –Travis County Region 7,* Central Health (2012)
- *Valuing the Youth Counseling Program (BTCS) – Fayette County Region 7, Central Healt*h (2012)
- *Valuing the Substance Abuse Treatment Program (BTCS) – Guadalupe County Region 6 , University Health System* (2012)

These valuation studies used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value per QALY gained due to the intervention multiplied by number of participants. A complete write-up of project will be available at performing provider site.
Total Five Year Valuation: $4,268,280

References:
Womble, K, Budget Cuts For State Mental Health Programs Lead To Crowded Emergency Rooms, Think Progress Health, 2012, thinkprogress.org/health.
Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (April 5, 2012). *The NSDUH Report: Physical Health Conditions among Adults with Mental Illnesses*. Rockville, MD.
Jeremy A. Chiles et al. The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review Clinical Psychology: Science and Practice, June 1999, Vol. 6.
Pallak, M. S., et al., "Medical costs, Medicaid, and managed mental health treatment: the Hawaii study", **Managed Care Q**, 1994 spring; 2 (2).

121988304.1.1	***1.12.2***	***N/A***	Expand number of community based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression / Trauma Counseling Centers)
Lakes Regional MHMR Centers			121988304
Related Category 3 Outcome Measure(s): *OD-10*	*121988304.3.1*	*IT-10.1*	***Quality of Life***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for a transportation program). **Metric 1 [**Manual of operations for the project detailing administrative protocols and clinical guidelines - **P-3.1]**: **Baseline/Goal:** Project Plan Stakeholder survey data gathered. Data gathered on Treatment models. EMR reports for client transfer eligibility. Determination of clinic capacity. Software options gathered. Location information for real estate/leasing agents gathered. **Data Sources**: Program Plan and files. Survey data pool. HR records. **Milestone 1 Estimated Incentive Payment *(maximum amount):* $274,814** **Milestone2 [P-4]:** Hire and train staff to operate and manage projects selected. **Metric 2** [Number of staff secured and trained – P-4.1]: **Goal:** 1 Support staff and 1 Program Coordinator hired and trained in new employee orientation and state requirements. **Data Source**: HR records **Milestone 2 Estimated Incentive Payment: $274,814**	**Milestone 3** [P-4]: Hire and train staff to operate and manage projects selected. **Metric 3** [Number of staff secured and trained – P-4.1]: **Goal:** Hire and train counseling staff in basic requirements of operational and clinical software in three (3) counseling centers (9-12 staff). Clinicians are additionally trained in chosen evidence-based therapy models, screening and referral. **Data Sources:** HR records, training certificates. **Milestone 3 Estimated Incentive Payment *:* $584,560** **Milestone 4 [P-6]:** Establish behavioral health services in new community -based settings in underserved areas. **Metric 4** [Number of new community-based settings where behavioral health services are delivered – P-6.1]: **Goal:** Three counseling centers open and providing services rendered. Enhanced professional training accomplished. Target Baseline number of clients served = 190. PDSA process cycles in place to inform project development, efficiency and effectiveness. **Data Source:** Client records, schedules Reports of PDSA reviews. **Milestone 4 Estimated Incentive Payment: $584,560**	**Milestone 5** [I-11]: Increased utilization of community behavioral healthcare. **I-11.1. Metric 5 [**Percent utilization of community behavioral healthcare services – I-11.1]: **Goal:** Expansion of population target of 20% over DY3 baseline = 228 new unique individuals served in treatment is met. PDSA cycle complete with report and improvement targets. **Data Source**: Schedules, client rosters, chart reviews. PDSA document. **Milestone 5 Estimated Incentive Payment *:* $637,266** **Milestone 6 [I-14]**: Improved Consumer satisfaction with Access **Metric 6** [>40% of people reporting satisfaction with access to care – I-14.1]: **Goal:** Satisfaction scores on participant surveys using the MHSIP instrument. PDSA cycle improvements. **Data Source**: Participant surveys and reports. PDSA improvement reports. **Milestone 6 Estimated Incentive Payment *:* $637,266**	**Milestone 7** [I-11]: Increased utilization of community behavioral healthcare. **I-11.1. Metric 7 [**Percent utilization of community behavioral healthcare services – I-11.1]: **Goal:** Expansion of population target of 30% over DY4 = 297 new unique individuals in treatment is met. PDSA cycle complete with report and improvement targets. **Data Source:** Schedules, client rosters, chart reviews. PDSA document. **Milestone 7 Estimated Incentive Payment *:* $637,500** **Milestone 8 [I-14]**: Improved Consumer satisfaction with Access **Metric 8** [>60% of people reporting satisfaction with access to care – I-14.1]: **Goal:** Satisfaction scores on participant surveys using the MHSIP instrument. PDSA cycle improvements. **Data Source:** Participant surveys and reports. PDSA improvement reports. **Milestone 8 Estimated Incentive Payment*:* $637,500**

Year 2 Estimated Milestone Bundle Amount: **$549,628**	Year 3 Estimated Milestone Bundle Amount: **$1,169,120**	Year 4 Estimated Milestone Bundle Amount: **$1,274,532**	Year 5 Estimated Milestone Bundle Amount: **$1,275,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: **$4,268,280**			

Project Option: 1.8.6 The Expansion of Existing Dental Clinics, the Establishment of Additional Dental Clinics, or the Expansion of Dental Clinic Hours
Unique Project Identification Number: 127278302.1.1 (Pass 1)
Performing Provider Name/TPI: UTHSCT- MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler (UTHSCT) is the sole academic medical center in Region 1. The organization includes a 109-bed acute care hospital, medical residency programs in Family Practice, Occupational Medicine, and Internal Medicine, and a state-of-the-art cancer treatment center, opened in 2011. University Physician Associates (UPA) comprises the physician faculty practice whose members participate in clinical care, medical and health professions training, and research to advance the institution's traditional three-pronged academic mission. UTHSCT and UPA have a long-standing history of expertise treating chest diseases including chronic respiratory illness and cardiovascular conditions with attendant co-morbidities such as diabetes. They serve patients from the largest rural population of the state. Tyler Junior College (TJC) offers an Associate level degree in dental hygiene among its accredited programs. This degree culminates in licensed oral health professionals who focus on preventing and treating oral diseases. The program is presently served by full-time, adjunct, and volunteer faculty from the community including licensed hygienists and dentists who supervise students.

Intervention(s): UPA is comprised of two principle primary care clinics (the Family Medicine Center and a General Internal Medicine Clinic/Center for Healthy Aging) along with a large cardiopulmonary ambulatory facility and cancer treatment center. There are smaller targeted medical and surgical specialty services on the campus of UTHSCT (Smith County). Additionally, UPA includes three external clinic sites, two of which are rurally located within medical underserved populations (Upshur County and Rusk County). General pediatric patients and pediatric pulmonary patients are cared for within these departments and clinics as well as in other specialized clinics such as a Cystic Fibrosis center. Presently, these ambulatory operations do not offer any form of dental care services nor do they have ready access to referral for dental preventive services. UPA/UTHSCT will partner with TJC by recruiting and hiring joint faculty services in dentistry and dental hygiene in order to establish a ready and timely referral mechanism for UPA patients who are underserved or do not have access to dental preventive services.

Need for the Project: The Texas Dental Association, in 2008, recommended a more aggressive strategy for addressing poor oral health in the state through prevention by focusing on low-income children, nursing home residents/elderly, individuals with special health care needs, low-income adults, and residents of medically underserved areas. These parameters characterize the demography of the Northeast Texas region and the patient population served by UPA/UTHSCT. The supply ratios of dentists and dental hygienists in Texas lag considerably behind those of the U.S. This shortage is more pronounced in rural areas such as the UTHSCT/UPA service area. This project aims to address Community Need (CN) 1, insufficient access to primary and specialty health care, as well as CN.6, efficiency in and effectiveness of health care delivery.

Target Population: During 2011, there were 11,976 patients with unique medical record numbers seen at UTHSCT, who come predominantly from the Region 1 service area, in particular the three counties where project clinics are located. Total primary care clinic visits approached 48,000 with payer mix including Medicaid 18.3 percent and self-pay 25.1 percent. Nearly 50 percent of Emergency Department (ED) visits

were Medicare and Medicaid. In short, the project will help to provide increased and timely access to dental preventive services to a population with a large share of indigent and Medicaid patients.

Category 1 or 2 Expected Patient Benefits: The expected outcome of this project will be to develop/implement a sustainable dental services access plan for this network of clinics, increase the number of preventive visits conducted in a timely manner through a new TJC dental clinic with 30 student operatories, and build capacity of dental hygiene graduates in this region. As this is a proposed new program for this patient population, baseline data will be established in DY3 with increased participation of 10% by DY5. This project is expected to cover a base patient population of 3,210, with unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, up to 543 patients/clients will receive or be engaged in dental preventive services (volume = 1,085 visits) by DY5, who did not previously have direct access to such services. The improvement milestone selected for this project to increase dental care training through referrals of patients with chronic disease to dental hygiene students directly reflects the quantitative impact of the project on the population served.

Category 3 Outcomes: IT-7.8 – Untreated oral disease can lead to serious and sometimes life threatening conditions which can be complicated by emergency department visits and extended hospital stays. The principle goal of this project is to increase the percentage of patients with chronic disease conditions who are able to access dental preventive services following referral by their medical provider. The downstream impact will help to reduce morbidity, mortality, and cost associated with advanced disease. Improvement target levels for DY4 and DY5 are to be determined.

Project Narrative

Project Description: Rural communities differ in population density, remoteness from urban areas, and in other cultural, economic, and social characteristics. Generally, the smaller, poorer, and more isolated these communities, the less accessibility there is to high-quality health services. (AAMC, 2012) In 2001, the Institute of Medicine (IOM) published its landmark report *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report called for fundamental changes in a health care system with serious shortcomings. A series of *Quality Chasm* reports have since followed including one on The Future of Rural Health Care. (IOM, 2005) In it, the IOM crafted a multi-pronged strategy to address quality challenges in rural communities. Among these strategies was a recommendation to: "Enhance the human resource capacity of rural communities, including the education, training, and deployment of health care professionals, and the preparedness of rural residents to engage actively in improving their health and health care."

By some conservative estimates, dental services make up nearly 5 percent of the total health care expenditures in the United States, funded predominantly by private sources. (IOM, 2005) In 2010, estimated U.S. expenditures were $108 billion. (CDC, 2011) As dental insurance coverage correlates strongly with family income, there are fewer resources available for rural populations such as Region 1 to receive dental care. The guiding principles for reforming rural health care provided that dental care should be part of the core set of health care services available to rural communities. In general, rural areas depend more heavily on midlevel clinicians such that for oral health care, some pilot studies identified in this *Quality Chasm* report have shown positive outcomes related to expansion of the scope of practice for dental hygienists.

Oral health is recognized as an important contributor to overall health, and oral exams are important for the detection of nutritional deficiencies and systemic diseases such as infections, immune disorders, and some cancers. There have been recent links between oral health, periodontal disease (4-12% of U.S. adults), and oral infections with other health conditions such as diabetes, cardiovascular disease, premature/low-

weight births, and bacterial pneumonia. (de Oliveira et al., 2010; CDC, 2011; TDA, 2008) Most oral diseases are preventable with population-based and community approaches. Thus, inadequate access or reduced resources for care results in increased cost beyond dental disease. (IOM, 2005) This is particularly pronounced among rural populations and in vulnerable groups with socioeconomic as well as racial and ethnic disparities. Lack of access due to an inadequate supply of providers, few who accept discounted fee schedules, and financial/payment programs which do not cover routine dental care further intensify the situation.

None-the-less, there are models whereby rural community health centers have been able to expand their services to include dental care. For example, in 2002, a community health center in Weber County, Utah created a partnership with the local university's (Weber State University) dental hygiene program to provide dental care at minimal cost. In exchange, the University was able to collaborate with a community dentist to offer supervision for its dental hygiene students who were able to offer preventive care combined with patient education. (IOM, 2005)

The **goal** of this DSRIP project addresses regional goals is to simultaneously **increase access** to preventive dental care services while increasing and enhancing the dental workforce able to provide care to underserved community members in Region 1. (Texas Health and Human Services Commission, 2012) University Physician Associates (UPA) at The University of Texas Health Science Center at Tyler (UTHSCT) is comprised of two principle primary care clinics (the Family Medicine Center and a General Internal Medicine Clinic/Center for Healthy Aging) along with a large cardiopulmonary ambulatory facility and cancer treatment center. There are smaller targeted medical and surgical specialty services on the campus of UTHSCT (Smith County). Additionally, UPA includes the following three external clinic sites, the latter two of which are rurally located within medical underserved populations – University Health Clinic on the campus of the University of Texas at Tyler in Smith County, Gladewater in Upshur County, and Overton in Rusk County. General pediatric patients and pediatric pulmonary patients are cared for within these departments and clinics as well as in other specialized clinics such as a Cystic Fibrosis center. Presently, these ambulatory operations do not offer any form of dental care services nor do they have ready access to referral for dental preventive services.

Tyler Junior College (TJC) has served the community since 1926 with quality instruction in a wide range of technical and pre-professional health science areas leading to two-year degrees at the Associate level. TJC has credit enrollment of more than 15,000 students annually. Dental hygiene is among the accredited programs (American Dental Association Commission on Dental Accreditation) offered, culminating in licensed oral health professionals who focus on preventing and treating oral diseases. The program is presently served by four full-time faculty (masters level) and numerous adjunct and volunteer faculty from the community including licensed hygienists and dentists who supervise students in 24 operatories.

UPA/UTHSCT will partner with TJC by recruiting and hiring joint faculty services in dentistry and dental hygiene in order to establish a ready and timely referral mechanism for UPA patients who are underserved or do not have access to dental services, in order to receive dental preventive care by TJC dental hygiene students under careful supervision of faculty. With a Family Medicine Residency (FMR) training program and primary care in an evolving Patient Centered Medical Home, expanded access to this level of dental services is essential for improving graduate medical education and the overall health of chronic disease patients.

Challenges to accomplishing this goal will include critical barriers to the recruitment and retention of dentistry/dental hygiene expertise. Other **challenges** include limited personnel resources in smaller rural clinic operations, and barriers to compatibility of electronic health records and integration with data collection systems which will permit bidirectional communication between primary care provider and dental services. The project will address these challenges early by recruiting or negotiating arrangements to fill these gaps in expertise. Additionally, healthcare team professionals will be trained on processes, guidelines, and technology which will optimize timely referrals to and consultation with dental preventive services.

The **expected outcome** by the conclusion of the project in DY5 will be to develop/implement a sustainable dental services **access** plan for this network of clinics, and increase the number of preventive visits conducted in a timely manner through a new TJC dental clinic. The second anticipated outcome is to collaborate locally between two key academic institutions to offer a community service which will provide the necessary experiential training for dental hygiene students who are likely to be retained in the region, thereby building capacity. FMR training will also be enhanced. This will also result in performance achievement of Category 3 intervention targets supportive of **improved patient experience** in keeping with **regional goals**.

Starting Point/Baseline: The following represent total outpatient volumes for UPA/UTHSCT Clinics for calendar year 2011, which serve as a projection of base **clients to be served** by the dental clinic at TJC.

Metric	**2011**
Total Primary Care Clinic Visits	47,966
Outpatient Visits to Primary Care at UTHSCT (FM physicians – 9, FM residents – 24, IM physicians – 5)	37,827
Overton Clinic (1 FM physician)	5,030
Gladewater Clinic (1 FM physician)	2,671
University Health Clinic (1 FM physician)	2,438

The patient payer mix during this time frame for both hospital (UTHSCT) and physicians (UPA) was as follows: Medicare 36.9 percent, Medicaid 18.3 percent, self-pay 25.1 percent, and commercial/other 19.7 percent. Nearly 50 percent of Emergency Department (ED) visits were Medicare and Medicaid. In excess of 75 percent of hospital discharges in 2011 were from a primary care service, Family Medicine (FM) or Internal Medicine (IM). These ED visits and discharges also originate from the patient populations of the external clinics. Unlike children, adult Medicaid does not cover dental care such that the poorest Texans have limited access to dental programs through government funding.

The development and implementation of a new dental preventive care plan which addresses services for this network of clinics is an intended outcome of this project. Therefore, there is no additional **baseline** information currently available. As DY2 and DY3 of this project will largely be focused on a dental preventive care access plan, training operations providers and staff, and recruitment of dental expertise, the proposed **time period** to be used as a **baseline** of **clients served** will be from calendar year 2014.

Rationale: Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. UTHSCT (with its UPA faculty) is the only academic health science center in this region drawing its patient base from the population of nearly 1.5 million Texans who reside in this corner of the state. The region has higher numbers of uninsured residents with 54 percent of these Texans either uninsured or enrolled in some form of publicly funded insurance. The region is more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. Metropolitan counties account for just 46 percent of the region's population compared with 87 percent for all Texas residents. (Combs, 2008) Nearly 90 percent of the 28 counties in RHP 1 (all except for three) are considered Primary Medical Care Health Professional Shortage Areas (U. S. Health Resources Services Administration). During 2011, there were 11,976 patients with unique medical record numbers seen at UTHSCT, who come predominantly from this service area, in particular the three counties where UTHSCT clinics are located.

In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. Findings of this assessment revealed higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. (Texas DSHS, 2007) The

majority of counties in Region 1 have higher rates of preventable hospitalizations related to pneumonia, dehydration, urinary tract infection, low birth weight, congestive heart failure, high blood pressure, asthma and diabetes as compared to the statewide rates. Furthermore, the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute 2011 *County Health Rankings* demonstrate how a large number of the counties in this region have health outcome rankings below the median for the state. (University of Wisconsin Population Health Institute, 2012). Median household income is also well below that of Texas as a whole including Upshur and Rusk Counties. Overall health system performance has recently been judged in the bottom quartile of the nation in much of Texas including Region 1. (Radley et al., 2012)

Untreated oral disease can lead to serious and sometimes life threatening conditions which can be complicated by emergency department visits and extended hospital stays. (TDA, 2008) Diabetics with severe gum disease are three times more likely to succumb to combined renal/cardiac dysfunction compared with groups with lesser gum disease. In Texas, a state with high and growing diabetes rates, only half of dentate diabetic patients receive an annual dental exam (among the lowest rates in the nation).

The Texas Dental Association, in 2008, recommended a more aggressive strategy for addressing poor oral health in the state through prevention by focusing on low-income children, nursing home residents/elderly, individuals with special health care needs, low-income adults, and residents of medically underserved areas. (TDA, 2008) These parameters characterize the demography of the Northeast Texas region and the patient population served by UPA/UTHSCT. The supply ratios of dentists and dental hygienists in Texas lag considerably behind those of the U.S. (TX DSHS, 2008) and is more pronounced in rural areas such as Region 1. Specifically, Smith, Rusk, and Upshur Counties all carry dental health professional shortage area designations with ratios in Rusk and Upshur being nearly twice and three times the national average respectively.

The University of Texas Health Science Center at Tyler and UPA have a long-standing history of expertise treating chest diseases including chronic respiratory illness and cardiovascular conditions. It is in this context that the project is a strategic match for UTHSCT with its mission targeted at providing excellent patient care and community health for those with chronic disease. The institution joined The University of Texas System in 1977 and today, the academic medical center consists of a 109-bed hospital, outpatient clinics including family medicine and internal medicine, and satellite clinics serving more rural communities. It has been home to an ACGME accredited Family Medicine Residency since 1985, graduating over 130 physicians, more than half of which have stayed in the Northeast Texas region. The strength of UTHSCT primary care has grown from the long-standing provision of these services to patients with chronic lung and cardiovascular disease. Three satellite Family Medicine primary care clinics located in Overton, East Tyler, and Gladewater serve rural residents of Northeast Texas. The patient population of UTHSCT with a history of chronic lung disease is roughly 50 percent rural (Coultas 2012, personal communication) with the same demographic pattern anticipated for patients with other chronic disease morbidities.

TJC has recently embarked upon new building construction of a $50 million Nursing and Health Science facility which will be the new home of the Dental Hygiene Program as well as a dental clinic which will provide state-of-the-art dental diagnosis and treatment options and patient education for the surrounding Tyler and East Texas communities. Spacious waiting rooms and a smart patient flow model will create a positive patient experience within this facility containing up to 30 dental operatories. The clinic will be staffed by dental professionals, in partnership with UPA/UTHSCT, that include licensed dentists, licensed dental hygienists, certified dental assistants, and students serving oral health care needs. The clinic, within this new facility, will serve the public, including uninsured and low-income patients and the elderly with limited dental literacy, as well as children. Work will be performed by licensed dentists and hygienists and certified dental assistants, supported by students in the dental hygiene and dental assisting programs. The project will also permit a level of increased interaction between Family Medicine Residents and dental professionals, engaging both in

understanding and learning about team roles and quality improvement related to dental preventive referrals and their impact on patient care and outcomes for those with chronic diseases.

The rationale for this proposal harmonizes with the rationale given for this DSRIP **project option** 1.8.6, with its single **core project component**, the expansion of existing dental clinics. This project will fall primarily within **Community Need** 1 or CN.1, insufficient access to primary and specialty health care, as well as in CN.6, efficiency in and effectiveness of health care delivery. Given the absence of dental preventive services within the UPA network of clinics, this represents **a new initiative**. Improving access to dental preventive services will be achieved through a series of steps as follows:

- A **gap** in access to preventive dental services and education has been identified. The initial step will be to develop/implement a dental preventive services and patient education access **plan** which addresses this newly available service for patients of this network of clinics. These services will include initial and follow-up examinations, basic/fundamental dental imaging, adult and child prophylaxis including cleaning, sealants, fluoride varnish applications, etc., and dental care education. A modest visit co-pay will be applied.
- Recruit and/or negotiate arrangements for dentist/dental hygiene faculty to have joint appointment between UPA/UTHSCT and TJC
- **Train/educate** project team professionals on processes, guidelines, and technology which will optimize timely referrals to and consultations for dental preventive services
- Implement coordinated referrals across the network of clinics
- Conduct **quality improvement** activities to identify barriers to timely referral consultation, assess success of bidirectional communication between primary care and dental providers through efforts to integrate oral health information with electronic medical records where possible, etc. Plan-Do-Study-Act (PDSA) or similar methodology will be used.

Related Category 3 Outcome Measure(s): Process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to improve access to dental preventive services as outlined above. These include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, a single standalone measure is selected from the domain Oral Health (OD-7). Specifically, this will be IT-7.8, Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider. **Evidence** suggests that untreated oral disease can lead to serious and sometimes life threatening conditions which can be complicated by emergency department visits and extended hospital stays. (TDA, 2008) Diabetics with severe gum disease are three times more likely to succumb to combined renal/cardiac dysfunction compared with groups with lesser gum disease. These oral health conditions are largely preventable through improved access to dental preventive services. Through collaboration with a well established dental hygiene training program at TJC and a new state-of-the-art facility currently under construction, the patients of the UPA/UTHSCT network of ambulatory clinics will gain access to dental preventive services and patient education previously unavailable. The result will be improved patient experience, reduced overall turnaround time for dental procedures, and improved efficiency of practitioners. The ultimate **focus** of this intervention in **RHP 1** is to **improve health outcomes of the lower income populations** that are disproportionately affected.

Relationship to other Projects: Sponsored by an academic medical center affiliate, this project is inter-related and contributes infrastructure, clinical, and educational expertise to benefit the following RHP project(s):
127278302.2.1 – Enhance/Expand Medical Homes for UPA Primary Care Clinics
127278302.2.15 Pass 3b (127278302.2.3) – Enhance Palliative Care Through Early Intervention

The project could also have implications for **Category 4** measures such as patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.
Relationship to Other Performing Providers' Projects in the RHP: not applicable

Plan for Learning Collaborative: Providers will participate in the learning collaborative through The Northeast Texas Center for Rural Community Health. The Center will help to coordinate semi-annual meetings/seminars between providers of UPA/UTHSCT and the Dental Hygiene Program at TJC for case review and to promote collaborative learning and improvement methods such as identification of best practices.

Project Valuation: Oral health is recognized as an important contributor to overall health. (IOM, 2005) There have been recent links between oral health, periodontal disease (4-12% of U.S. adults), and oral infections with other health conditions such as diabetes, cardiovascular disease, premature/low-weight births, and bacterial pneumonia. (de Oliveira et al., 2010; CDC, 2011; TDA, 2008) Most oral diseases are preventable with population-based and community approaches. Untreated oral disease can lead to serious and sometimes life threatening conditions which can be complicated by emergency department visits and extended hospital stays. (TDA, 2008) This project is intended to improve access to dental preventive services to the UPA/UTHSCT network of clinics and patient population (Smith, Upshur, and Rusk Counties). Development and implementation of a plan to increase access to dental preventive services previously unavailable to vulnerable rural patients will help to create an efficient referral system resulting in timely care. Use of Category 3, evidence-based outcome measures which demonstrate this level of increased access is intended to improve quality of care. This infrastructure investment to build capacity in dental personnel will simultaneously help to reduce the financial costs to the regional health care system through provision of preventive dental services recognized to reduce the burden of chronic disease. The value of this project is justifiable on the basis of:

- Addressing priority regional community needs .
- Enhanced access to dental preventive services for a rural/vulnerable population and to promote early intervention measures which may contribute to reduction of chronic disease morbidity.
- Improved coordination of care resulting in more timely delivery.
- Building capacity and sustainability through process development, recruitment and training of dental professionals, and training family medicine residents in appropriate referral for oral health services.
- Engagement of large stakeholders in collaborative service delivery in RHP 1.

References:

Association of American Medical Colleges (AAMC). AAMC physician workforce policy recommendations, September 2012. Available at: https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendations.pdf (last accessed 10-06-2012).

Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health. Oral health: preventing cavities, gum disease, tooth loss, and oral cancers, 2011. Available at: http://www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm (last accessed 10-13-2012).

Combs S. Texas in Focus: Upper East Texas, 2008. Available at http://www.window.state.tx.us/specialrpt/tif/uppereast/ (last accessed 10-04-2012).

Institute of Medicine. Quality through collaboration: the future of rural health. Washington, D.C.: The National Academies Press, 2005, 288 pp. Available at http://www.nap.edu/catalog/11140.html (last accessed 10-01-2012).

de Oliveira C, Watt R, Hamer M. Toothbrushing, inflammation, and risk of cardiovascular disease: results from Scottish Health Survey. *BMJ* 2010;340:c2451. Available at http://www.bmj.com/content/340/bmj.c2451.pdf%2Bhtml (last accessed 10-13-2012).

Radley DC, How SKH, Fryer A-K, McCarthy D, Schoen C. Rising to the challenge: results from a scorecard on local health system performance, 2012. The Commonwealth Fund 2012, 102 pp. Available at http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx (last accessed 10-01-2012).

Texas Dental Association (TDA). Building better oral health, 2008. Available at: http://www.buildingbetteroralhealth.org/ (last accessed 10-13-2012).

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10-04-2012).

Texas Department of State Health Services (TX DSHS) and Statewide Health Coordinating Council, Health Professions Resource Center for Health Statistics. Promoting excellence through healthcare workforce planning in Texas. Publication No. 25-12901. February 2008. Available at: www.dshs.state.tx.us/chs/hprc/shp07ch2.pdf (last accessed 10-13-2012).

Texas Health and Human Services Commission. Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

University of Wisconsin Population Health Institute. County Health Rankings: Mobilizing Action Toward Community Health – Texas, 2012. Available at http://www.countyhealthrankings.org/texas/ (last accessed 10-04-2012).

127278302.1.1	***1.8.6***	***1.8.6***	***INCREASE, EXPAND, AND ENHANCE ORAL PREVENTIVE SERVICES***	
		University Physician Associates		*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.1*	*3.IT-7.8*	Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 *P-6*: Implement/expand alternative dental care delivery system to underserved population Metric 1 *P-6.6*: Memorandum of Understanding (MOU)/ collaborative agreement (CA) Baseline/Goal: New program for this patient population Data Source: Documentation of MOU/CA Milestone 1 Estimated Incentive Payment (*maximum amount)*: $1,233,442 **Milestone 2** *P-3*: Increase interdisciplinary training/ education to promote team approach to oral health Metric 1 *P-3.1*: Grand rounds, continuing ed that focuses on oral health/relation to chronic disease Baseline/Goal: New program for this patient population Data Source: Documentation of training, attendance rosters Milestone 2 Estimated Incentive Payment (*maximum amount)*: $1,233,442		**Milestone 3** *P-4*: Establish additional/expand existing/ relocate dental care clinics or space Metric 1 *P-4.1*: Number of additional clinics, expanded space, or existing available space used to capacity Baseline/Goal: New program for this patient population Data Source: Documentation of expansion or efficient use of existing space and/or dental care schedules Milestone 3 Estimated Incentive Payment: $1,106,832	**Milestone 4** *I-11*: Increase dental care training Metric 1 *I-11.3*: Increase number or percent of healthcare providers that have participated in interdisciplinary approach to providing oral health care Goal: Increase by 5% over baseline to be established by DY3 Data Source: Documentation of didactic as well as practical training Milestone 4 Estimated Incentive Payment: $1,012,096	**Milestone 5** *I-11*: Increase dental care training Metric 1 *I-11.3*: Increase number or percent of healthcare providers that have participated in interdisciplinary approach to providing oral health care Goal: Increase by 10% over baseline to be established by DY3 Data Source: Documentation of didactic as well as practical training Milestone 5 Estimated Incentive Payment: $858,982 Number of people potentially served in DY5 = 543 Volume of service anticipated in DY5 = 1,085
Year 2 Estimated Milestone Bundle Amount: $2,466,884		Year 3 Estimated Milestone Bundle Amount: $1,106,832	Year 4 Estimated Milestone Bundle Amount: $1,012,096	Year 5 Estimated Milestone Bundle Amount: $858,982
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $5,444,794				

Project Option: 1.9.2 - Expand Specialty Care Capacity
Unique Project Identification Number: 127278302.1.9 Pass 3b (127278302.1.2 (Pass 1))
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler (UTHSCT) is the sole academic medical center in Region 1. The organization includes a 109-bed acute care hospital, medical residency programs in Family Practice, Occupational Medicine, and Internal Medicine, and a state-of-the-art cancer treatment center, opened in 2011. University Physician Associates (UPA) comprises the physician faculty practice whose members participate in clinical care, medical and health professions training, and research to advance the institution's traditional three-pronged academic mission. UTHSCT and UPA have a long-standing history of expertise treating chest diseases including chronic respiratory illness and cardiovascular conditions and serve the largest rural population of the state. It is in this context that the project is a strategic match for UTHSCT with its mission targeted at providing excellent patient care and community health for those with these chronic diseases and their attendant co-morbidities.

Intervention(s): UPA is comprised of two principle primary care clinics (the Family Medicine Center and a General Internal Medicine Clinic/Center for Healthy Aging) along with a large cardiopulmonary ambulatory facility and cancer treatment center. There are smaller targeted medical and surgical specialty services on the campus of UTHSCT (Smith County). Additionally, UPA includes three external clinic sites, two of which are rurally located within medical underserved populations (Upshur County and Rusk County). There are several key medical specialties absent within this integrated health network resulting in gaps in accessibility to timely and efficient care. Further, UTHSCT is the sponsoring institution for a newly formed mid-sized internal medicine residency (IMR) program in Longview, Texas in partnership with a large community hospital (Good Shepherd Medical Center - GSMC). The goal of this DSRIP project is to confirm specialty care gaps early and develop/implement a specialty care access plan which addresses targeted gaps in specialty care for this network of clinics as well as potential referrals from the GSMC IMR.

Need for the Project: Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. The region has higher numbers of uninsured residents with nearly 90 percent of the 28 counties in Region 1 (all except for three) considered as Primary Medical Care Health Professional Shortage Areas. The region has higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, and disproportionate disease burden among vulnerable populations. Median household income is also well below that of Texas as a whole, including much of the service area for both UPA and GSMC. Access to an adequate supply of well-educated, culturally competent, and highly trained physicians in rural areas is essential to deliver quality health care. It is also well recognized that patient populations with this level of chronic disease have multiple co-morbidities (such as diabetes) optimally receiving specialty care. This project aims to address Community Need 1, insufficient access to primary and specialty health care.

Target Population: During 2011, there were 11,976 patients with unique medical record numbers seen at UTHSCT, who come predominantly from the Region 1 service area, in particular the three counties where project clinics are located. Total primary care clinic visits approached 48,000 with payer mix

including Medicaid 18.3 percent and self-pay 25.1 percent. Nearly 50 percent of Emergency Department (ED) visits were Medicare and Medicaid. During calendar year 2012, there were 168,170 outpatient visits, 88,663 emergency department visits, and 36,000 admissions to GSMC, though the GSMC IMR is new and baseline numbers are yet to be established. In short, the project will help to provide increased and timely access to targeted specialty services to a population with a large share of indigent and Medicaid patients.

Category 1 or 2 Expected Patient Benefits: The expected outcome of this project is to increase the number of specialist providers and specialty care visits conducted in a timely manner for this patient population, thereby improving the quality of care and patient satisfaction, and reducing the cost of health care by improving early diagnosis and management of disease processes in a vulnerable rural population. The number of specialty care visits will be increased by 10% over baseline by DY5. This project is expected to cover a base patient/client population of 5,267, with unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, a service volume up to 1,160 will be delivered to patients/clients who will receive or be engaged in specialty care services by DY5, and who did not previously have direct access to such services. The improvement milestone selected for this project to increase the number of specialty care visits directly reflects the quantitative impact of the project on the population served.

Category 3 Outcomes: IT-1.12, 1.13, 1.14 – A goal of this project is to improve access to well recognized preventive services such as retinal eye exams, podiatric exams, and monitoring for nephropathy in a high prevalence diabetes population, thereby reducing morbidity, mortality, and cost associated with advanced disease. Improvement target levels for DY4 and DY5 are to be determined.

Project Narrative

Project Description: Rural communities differ in population density, remoteness from urban areas, and in other cultural, economic, and social characteristics. Generally, the smaller, poorer, and more isolated these communities, the less accessibility there is to high-quality health services. (AAMC, 2012) In 2001, the Institute of Medicine (IOM) published its landmark report *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report called for fundamental changes in a health care system with serious shortcomings. A series of *Quality Chasm* reports have since followed including one on The Future of Rural Health Care. (IOM, 2005) In it, the IOM crafted a multi-pronged strategy to address quality challenges in rural communities. Among these strategies was a recommendation to: "Enhance the human resource capacity of rural communities, including the education, training, and deployment of health care professionals, and the preparedness of rural residents to engage actively in improving their health and health care."

Access to an adequate supply of well-educated, culturally competent, and highly trained physicians in rural areas is essential to deliver quality health care. (AAMC, 2012) This statement becomes even more compelling as the Medicare age population continues to grow and as the Supreme Court upheld Affordable Care Act requires millions of Americans to become newly insured. Projections are that the United States will face a shortage of nearly 100,000 doctors by 2020, and underserved populations will continue to carry the heaviest burden of both a primary care workforce and specialist shortage.

Texas, both urban and rural, has not been spared from this shortage of physicians and specialists. The **goal** of this DSRIP project is "to increase the capacity to provide specialty care services

and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services." (Texas Health and Human Services Commission, 2012) University Physician Associates (UPA) at The University of Texas Health Science Center at Tyler (UTHSCT) is comprised of two principle primary care clinics (the Family Medicine Center and a General Internal Medicine Clinic/Center for Healthy Aging) along with a large cardiopulmonary ambulatory facility and cancer treatment center. There are smaller targeted medical and surgical specialty services on the campus of UTHSCT (Smith County). Additionally, UPA includes the following three external clinic sites, the latter two of which are rurally located within medical underserved populations – University Health Clinic on the campus of the University of Texas at Tyler in Smith County, Gladewater in Upshur County, and Overton in Rusk County. There are several key medical specialties absent within this integrated health network resulting in gaps in accessibility to timely and efficient care. With primary care in an evolving Patient Centered Medical Home, expanded access to these targeted specialty care areas is essential.

Challenges to accomplishing this goal will include critical barriers to the recruitment and retention of specialty expertise in a number of areas delivered directly on the campus of UTHSCT and/or through affiliations within the community for selective specialty referral coordination and facilitation. Other **challenges** include limited personnel resources in smaller rural clinic operations, and barriers to full implementation of electronic health records and integration with data collection systems which will permit bidirectional communication between primary care provider and specialist. The project will address these challenges by confirming specialty care gaps early and recruiting or negotiating arrangements to fill these gaps within the UPA patient care network of clinics. Additionally, healthcare team professionals will be trained on processes, guidelines, and technology which will optimize timely referrals to and consultations by selected medical specialties.

This project is designed to make a significant impact on the following **regional goals:** 1) Improve access to health care services by increasing service availability and specialty clinic locations, 2) improve the quality of care and patient satisfaction by optimizing timely referrals to and consultations with selected medical specialties, and 3) reduce the cost of health care by improving early diagnosis and management of disease processes.

The **expected outcome** by the conclusion of the project in DY5 will be to develop/implement a sustainable specialty care access plan which addresses targeted gaps in specialty care for this network of clinics, and increases the number of specialist providers and specialty care visits conducted in a timely manner. This will also result in performance achievement of Category 3 intervention targets supportive of improved patient experience in keeping with regional goals.

Starting Point/Baseline: The following represent total outpatient volumes for UPA/UTHSCT Clinics for calendar year 2011, which serve as a projection of base **clients to be served** by these respective clinics, specifically Primary Care and the Emergency Department of UPA and UTHSCT respectively.

Metric	**2011**
Total Primary Care Clinic Visits	47,966
Outpatient Visits to Primary Care at UTHSCT (FM physicians – 9, FM residents – 24, IM physicians – 5)	37,827
Overton Clinic (1 FM physician)	5,030
Gladewater Clinic (1 FM physician)	2,671
University Health Clinic (1 FM physician)	2,438
Emergency Department Visits	13,050

The patient payer mix during this time frame for both hospital (UTHSCT) and physicians (UPA) was as follows: Medicare 36.9 percent, Medicaid 18.3 percent, self-pay 25.1 percent, and commercial/other 19.7 percent. Nearly 50 percent of Emergency Department (ED) visits were Medicare and Medicaid. In excess of 75 percent of hospital discharges in 2011 were from a primary care service, Family Medicine (FM) or Internal Medicine (IM). These ED visits and discharges also originate from the patient populations of the external clinics.

The development and implementation of a specialty care access plan which addresses targeted gaps in specialty care for this network of clinics is an intended outcome of this project. Therefore, there is no additional **baseline** information currently available. As DY2 and DY3 of this project will largely be focused on a specialty care access plan, training care providers and staff, and recruitment of specialty expertise directly on the campus of UPA/UTHSCT and/or through affiliations within the community, the proposed **time period** to be used as a **baseline** of **clients served** will be from calendar year 2014.

Rationale: Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. UTHSCT (with its UPA faculty) is the only academic health science center in this region drawing its patient base from the population of nearly 1.5 million Texans who reside in this corner of the state. The region has higher numbers of uninsured residents with 54 percent of these Texans either uninsured or enrolled in some form of publicly funded insurance. The region is more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. Metropolitan counties account for just 46 percent of the region's population compared with 87 percent for all Texas residents. (Combs, 2008) Nearly 90 percent of the 28 counties in Region 1 (all except for three) are considered Primary Medical Care Health Professional Shortage Areas (U. S. Health Resources Services Administration). During 2011, there were 11,976 patients with unique medical record numbers seen at UTHSCT, who come predominantly from this service area, in particular the three counties where UTHSCT clinics are located.

In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. Findings of this assessment revealed higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. (Texas DSHS, 2007) The majority of counties in Region 1 have higher rates of preventable hospitalizations related to pneumonia, dehydration, urinary tract infection, low birth weight, congestive heart failure, high blood pressure, asthma, and diabetes as compared to the statewide rates. Furthermore, the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute 2011 *County Health Rankings* demonstrate how a large number of the counties in this region have health outcome rankings below the median for the state. (University of Wisconsin Population Health Institute, 2012). Median household income is also well below that of Texas as a whole including Upshur and Rusk Counties.

The University of Texas Health Science Center at Tyler and UPA have a long-standing history of expertise treating chest diseases including chronic respiratory illness and cardiovascular conditions. It is in this context that the project is a strategic match for UTHSCT with its mission targeted at providing excellent patient care and community health for those with chronic disease. The institution joined The University of Texas System in 1977 and today, the academic medical center consists of a 109-bed hospital, outpatient clinics including family medicine and internal medicine, and satellite clinics serving more rural communities. It has been home to an ACGME accredited Family Medicine Residency since 1985, graduating over 130 physicians, more than half of which have stayed in the Northeast Texas region. The strength of UTHSCT primary care has grown from the long-standing provision of these

services to patients with chronic lung and cardiovascular disease. Three satellite Family Medicine primary care clinics located in Overton, East Tyler, and Gladewater serve rural residents of Northeast Texas. The patient population of UTHSCT with a history of chronic lung disease is roughly 50 percent rural (Coultas 2012, personal communication) with the same demographic pattern anticipated for patients with other chronic disease morbidities.

An increasing public health focus has been driven by faculty who possess graduate degrees in public health and board-certification by the American Board of Preventive Medicine. UTHSCT is home to a Preventive Medicine Residency in Occupational Medicine since 1994. Preventive medicine is recognized among the "specialty areas of greatest need." (Texas HHSC, 2012, p. 99) UTHSCT is also the sponsoring institution for a newly formed mid-sized internal medicine residency (IMR) program in Longview, Texas in partnership with a large community hospital (Good Shepherd Medical Center - GSMC). This emphasis on post-graduate medical education training in primary care and prevention with academic and community hospital linkages uniquely positions UTHSCT/UPA to develop a project to increase specialty care services. Beyond enhancing the medical knowledge and clinical skills of residents, it affords them an opportunity to be engaged in understanding and learning about leadership roles for process development and quality improvement on matters such as the impact of specialty referrals on patient care and outcomes.

It is well recognized that patient populations with this level of chronic disease have multiple co-morbidities (such as diabetes) optimally receiving specialty care. The rationale for this proposal harmonizes with the rationale given for this DSRIP **project option** 1.9.2 to improve access to specialty care. This project will fall within **Community Need** 1 or CN.1, insufficient access to primary and specialty health care. Given the absence of targeted specialty care within the UPA network of clinics, this represents **a new initiative**.

Improving access to specialty care will be achieved through a series of steps to incorporate **core project components** as specified in Category 1 of the RHP Planning Protocol (Texas Health and Human Services Commission, 2012) as follows:

- Confirm specialty care **gaps** early. Targeted specialties of interest for consideration include ophthalmology, podiatry, nephrology, endocrinology/diabetes care, neurology/pain, infectious diseases, dermatology, and rheumatology
- Develop/implement a specialty care access **plan** which addresses targeted gaps in specialty care for this network of clinics as well as potential referrals from GSMC IMR
- Recruit or negotiate arrangements to fill these gaps within the UPA patient care network of clinics
- **Train/educate** healthcare team professionals on processes, guidelines, and technology which will optimize timely referrals to and consultations by selected medical specialties
- Increase service availability and specialty clinic locations
- Implement coordinated referrals across the network of clinics
- Conduct **quality improvement** activities to identify barriers to timely referral consultation, e.g., Plan-Do-Study-Act (PDSA)

Related Category 3 Outcome Measure(s): Process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to improve access to specialty care as outlined above. These include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort. In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Chronic Disease Management (OD-1). These will include Diabetes care: *Retinal eye exam* (IT-1.12), Diabetes

care: *Foot exam* (IT-1.13), and Diabetes care: *Microalbumin/Nephropathy* (IT-1.14). Diabetes is one of the most costly and highly prevalent chronic diseases in the United States, frequently undiagnosed. (AHQR, 2012) Complications are costly both financially and in terms of morbidity such as lower extremity amputation, retinopathy/blindness, and renal failure, all preventable with early and effective treatment. The National Committee on Quality Assurance (NCQA, expert consensus **evidence**) and the Healthcare Effectiveness Data & information Set (HEDIS) 2012 recommend periodic retinal eye exams and screening tests for nephropathy among those 18 to 75 years of age with Type I or Type II Diabetes. Further, **evidence** of higher rates of chronic disease prevalence in **Region 1** (including Diabetes morbidity) supports the selection of these particular measures and is likely to **focus** the application of specialty care in a manner which will **improve health outcomes of the lower income populations** served by UPA.

Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure, clinical, and educational expertise to benefit the following RHP project(s).

127278302.2.1 – Enhance/Expand Medical Homes for UPA Primary Care Clinics
127278302.2.14 Pass 3b (127278302.2.2) – Enhance/Expand Medical Home for GSMC Internal Medicine Residency Clinic
127278302.2.5 – Evidence-based Disease Prevention: Expand Delivery of Early Colon Cancer Treatment and Secondary Prevention Management
127278302.2.18 Pass 3b (127278302.2.7) – Integrate Primary and Behavioral Health Care Services
127278302.1.1 – Increase, Expand and Enhance Oral Health Preventive Services

The project could also have implications for **Category 4** measures such as patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.

Relationship to Other Performing Providers' Projects in the RHP: Providers will participate in the learning collaborative through The Northeast Texas Center for Rural Community Health (see below) as well as partnerships between residency programs as described.

Plan for Learning Collaborative: UTHSCT houses The Northeast Texas Center for Rural Community Health (The Center). The Center was established for the purpose of: 1) engaging in community health service activities within the Northeast Texas region and 2) enhancing, promoting, coordinating, and supporting faculty and student projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. Specific roles of the Center will be to: 1) convene internal and external stakeholders who will participate in Regional Health Plan development and facilitation; 2) facilitate Regional Health Plan meetings and communicate function and purpose of the Regional Health Plan; 3) assist with identification of community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project; 4) coordinate efforts within the Regional Health Plan including provision of a platform and process for identifying, improving, and facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence; 5) serve as a point of contact for the Regional Health Plan with Texas Health and Human Services; 6) lend scholarly and academic assistance to the design and implementation of DSRIP projects. Serving as a facilitator for regional data transmission will be a key function of the Center, tied closely to evaluation

of its success. UTHSCT will participate in a RHP-wide learning collaborative with other providers through the Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: Rural underserved populations continue to carry the heaviest burden of both a primary care workforce and specialist shortage. Infrastructure investment in this project is intended to improve access to specialty care within the UTHSCT/UPA network of clinics and patient population (Smith, Upshur, and Rusk Counties) as well as collaborate with the GSMC IMR. Assessment of the gaps in specialty services and implementation of a plan to increase targeted specialty access will help to create an efficient referral system which will result in timely care. Use of Category 3, evidence-based outcome measures which rely upon specialty care services such as endocrinology, ophthalmology, podiatry, and nephrology are intended to improve quality of care. Taken together, these benefits will help to reduce the financial burden to the regional health care system through early detection and management of disease, reduced morbidity, and reduced utilization of high costs services. The value of this project is justifiable on the basis of:

- Addressing CN.1, insufficient access to primary and specialty health care, by enhancing access to specialty care services for a rural/vulnerable population and to promote early intervention measures.
- Improved coordination of care resulting in more timely delivery and better compliance with recommended improvement targets.
- Building capacity and sustainability through process development, recruitment of specialty services, and training residents in appropriate specialty referral procedures.

References:

Agency for Healthcare Research and Quality (AHRQ), National Quality Measures Clearinghouse. Comprehensive diabetes care, HEDIS 2012. Available at: http://www.qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?orgid=8&objid=34614 (last accessed 10-06-2012).

Association of American Medical Colleges (AAMC). AAMC physician workforce policy recommendations, September 2012. Available at: https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendations.pdf (last accessed 10-06-2012).

Combs S. Texas in Focus: Upper East Texas, 2008. Available at http://www.window.state.tx.us/specialrpt/tif/uppereast/ (last accessed 10-04-2012).

Institute of Medicine. Quality through collaboration: the future of rural health. Washington, D.C.: The National Academies Press, 2005, 288 pp. Available at http://www.nap.edu/catalog/11140.html (last accessed 10-01-2012).

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10-04-2012).

Texas Health and Human Services Commission (HHSC). Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

University of Wisconsin Population Health Institute. County Health Rankings: Mobilizing Action Toward Community Health – Texas, 2012. Available at http://www.countyhealthrankings.org/texas/ (last accessed 10-04-2012).

127278302.1.9 PASS 3B (127278302.1.2)	***1.9.2***	***1.9.2.A-D***	***IMPROVE ACCESS TO SPECIALTY CARE FOR UPA***
University Physician Associates			*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.32 Pass 3b (127278302.3.2)*	*3.IT-1.12*	Diabetes care: *Retinal eye exam*
	127278302.3.33 Pass 3b (127278302.3.3)	*3.IT-1.13*	Diabetes care: *Foot exam*
	127278302.3.34 Pass 3b (127278302.3.4)	*3.IT-1.14*	Diabetes care: *Microalbumin/Nephropathy*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 *P-12*: Develop/implement specialty care access plan Metric 1 *P-12.1*: Documentation of specialty care access plan Baseline/Goal: 0/1 plan Data Source: Documentation of plan Milestone 1 Estimated Incentive Payment (*maximum amount)*: $2,237,490	**Milestone 2** *P-2*: Train care providers and staff on processes for specialty referrals Metric 1 *P-2.1*: Training of staff and providers on referral process Baseline/Goal: 0/1 training Data Source: Documentation of training Milestone 2 Estimated Incentive Payment: $1,090,351 **Milestone 3** *P-5*: Reports on days from referral receipt to referral appointment Metric 1 *P-5.1*: Reports on average referral process time Baseline/Goal: Establish baseline rate Data Source: Registry, EHR Milestone 3 Estimated Incentive Payment: $1,090,351	**Milestone 4** *I-33*: Increase specialty care capacity using innovative project option Metric 1 *I-33.2*: Increase number of specialty care visits Goal: Increase by 5% over baseline Data Source: Registry Milestone 4 Estimated Incentive Payment: $2,021,300	**Milestone 5** *I-33*: Increase specialty care capacity using innovative project option Metric 1 *I-33.2*: Increase number of specialty care visits Goal: Increase by 10% over baseline Data Source: Registry Milestone 5 Estimated Incentive Payment: $2,732,544 Number of people potentially served in DY5 = 5,267 Volume of service anticipated in DY5 = 1,160
Year 2 Estimated Milestone Bundle Amount: $2,237,490	Year 3 Estimated Milestone Bundle Amount: $2,180,703	Year 4 Estimated Milestone Bundle Amount: $2,021,300	Year 5 Estimated Milestone Bundle Amount: $2,732,544
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $9,172,037			

Project Option: 1.11.1 & 1.11.2 Implement technology-assisted services to support, coordinate, or deliver behavioral health services
Unique Project Identification Number: 127278302.1.10 Pass 3b (127278302.1.3 (Pass 1))
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The proposed infrastructure project would utilize University Physician Associates (UPA) at the University of Texas Health Science Center at Tyler (UTHSCT) as the hub for this telemental/telehealth network. The UTHSCT sponsored Northeast Texas Consortium and Center for Educational Technologies (NETnet), along with its partnering collaborators, the East Texas Interactive Healthcare Network and the SUPERnet K-12 Consortium, connects to more than 400 classrooms and medical sites throughout the northeast Texas region. NETnet also serves as the northeast Texas regional point-of-presence (PoP) for the Texas Lonestar Education and Research Network (LEARN), Texas' statewide higher education fiber optic network. LEARN provides Texas' fiber backbone for Internet2 services and broadband connectivity for the state's K-12 systems.

Intervention: This project will expand and enhance the infrastructure necessary to build targeted telemental/telehealth capacity within the Northeast Texas region including trained Community Health Worker presenters and integration of primary and behavioral health care services. The **high speed broadband communications technology** at NETnet will provide the network backbone to expand connectivity to and within nine rural counties (Anderson, Henderson, Cherokee, Gregg, Harrison, Marion, Upshur, Rusk, and Smith) and their respective behavioral health service providers (Palestine Regional Medical Center, Good Shepherd Health System, Community Health Core, and UTHSCT). In addition, the proposed network will extend connectivity between behavioral/primary care providers and criminal justice systems to support more appropriate and efficient case dispensation prior to patient transportation.

Need for the Project: Currently there is not a standardized mechanism for timely assessment of patients experiencing acute behavioral episodes; this results in inappropriate use of 1) transportation, 2) Emergency Departments (EDs), and 3) jails throughout Region 1.

Target Population: About 54% of the 1.5 million residents in the region are uninsured or enrolled in publicly funded insurance. The Texas Department of State Health Services (DSHS) has estimated that over 85,000 individuals in the region have a serious mental illness and that well over 100,000 need treatment for alcohol/drug use. A baseline for the target population will be established by the collaborating partners in DY3.
Category 1 Expected Patient Benefits: The project seeks to provide telemental consults between health care providers, behavioral health providers, and criminal justice system entities. Satisfaction with telemental services (I-15) will be improved by 5% in DY4 compared with DY3 established baseline and by 10% in DY5 compared with the baseline. This project is expected to cover a base patient/client populati0n of 9,357, with unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid recipients. Specifically, up to 677 patients/clients will receive or be engaged in

telemental services by DY5. The improvement milestone selected for this project to measure consumer/peer/provider satisfaction with each encounter directly reflects the quantitative impact of the project on the population served.

Category 3 Outcomes: IT-9.1, our goal is to decrease mental health admissions and readmissions to criminal justice settings such as jails or prisons by X% (TBD) in DY4 compared to the baseline established in DY3 and by an additional X% (TBD) compared to the DY3 baseline in DY5.

Project Description: Rural communities differ in population density, remoteness from urban areas, and in other cultural, economic, and social characteristics. Generally, the smaller, poorer, and more isolated these communities, the less accessibility there is to high-quality health services. (AAMC, 2012) In 2001, the Institute of Medicine (IOM) published its landmark report *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report called for fundamental changes in a health care system with serious shortcomings. A series of *Quality Chasm* reports have since followed including one on The Future of Rural Health Care. (IOM, 2005) In it, the IOM crafted a multi-pronged strategy to address quality challenges in rural communities. Among these strategies was a recommendation to: "Invest in building an information and communications technology (ICT) infrastructure, which has enormous potential to enhance health and health care over the coming decades."

Access to an adequate supply of well-educated, culturally competent, and highly trained physicians in rural areas is essential to deliver quality health care. (AAMC, 2012) Projections are that the United States will face a shortage of nearly 100,000 doctors by 2020, and underserved populations will continue to bear the heaviest burden of both a primary care workforce and specialist shortage. Psychiatry has been identified as one of the specialty areas of greatest need. (Texas HHSC, 2012, p.99). Texas, both urban and rural, has not been spared from this shortage of physicians and specialists including psychiatrists as well as other behavioral health providers.

Televideo technology has been proposed as a means to address these limitations of access to behavioral health services in remote or rural areas of the state. These so-called telemental health services "may include mental health assessments, treatment, education, monitoring, mentoring and collaboration." (Texas HHSC, 2012) These services can connect multiple geographic locations and many different provider types in a variety of settings. Its use could provide direct video access between psychiatrist, patient, and primary care provider as well as with evidence-based counseling protocols.

The **goal** of this DSRIP project is to expand and enhance the infrastructure necessary to build targeted telemental/telehealth capacity within the Northeast Texas region and to support other DSRIP project efforts directed at workforce development for facilitation of these services (trained Community Health Worker presenters) and integration of primary and behavioral health care services. The proposed infrastructure would utilize University Physician Associates (UPA) at the University of Texas Health Science Center at Tyler (UTHSCT) as the hub for this telemental/telehealth network. The Northeast Texas Consortium and Center for Educational Technologies (NETnet) is located on the UTHSCT campus, led by Executive Director, Mickey Slimp, EdD. Along with its partnering collaborators, the East Texas Interactive Healthcare Network and the SUPERnet K-12 Consortium, NETnet connects to more than 400 classrooms and medical sites throughout the northeast Texas region. NETnet also serves as the northeast Texas regional point-of-presence (PoP) for the Texas Lonestar Education and Research Network (LEARN), Texas'

statewide higher education fiber optic network. LEARN provides Texas' fiber backbone for Internet2 services and broadband connectivity for the state's K-12 systems.

This DSRIP project proposes to enhance existent state-of-the-art **high speed broadband communications technology** at NETnet as the backbone for establishing this telemental network. It will reach across several rural counties (Anderson, Henderson, Cherokee, Gregg, Harrison, Marion, Upshur, Rusk, and Smith) and their respective behavioral health service providers (Palestine Regional Medical Center, Good Shepherd Health System, Community Health Core, and UTHSCT). It will also add a unique component to management of behavioral crises and/or disruptive patients by facilitating combined medical as well as societal evaluation of individuals when questions of management location arise. The proposed network will extend a telemental connection between provider and criminal justice systems so that such determinations might be made more appropriately, readily, and efficiently and when a direct interaction is necessary prior to patient transportation. Hence, the network design below includes connectivity to community entities such as the county judge or local jail.

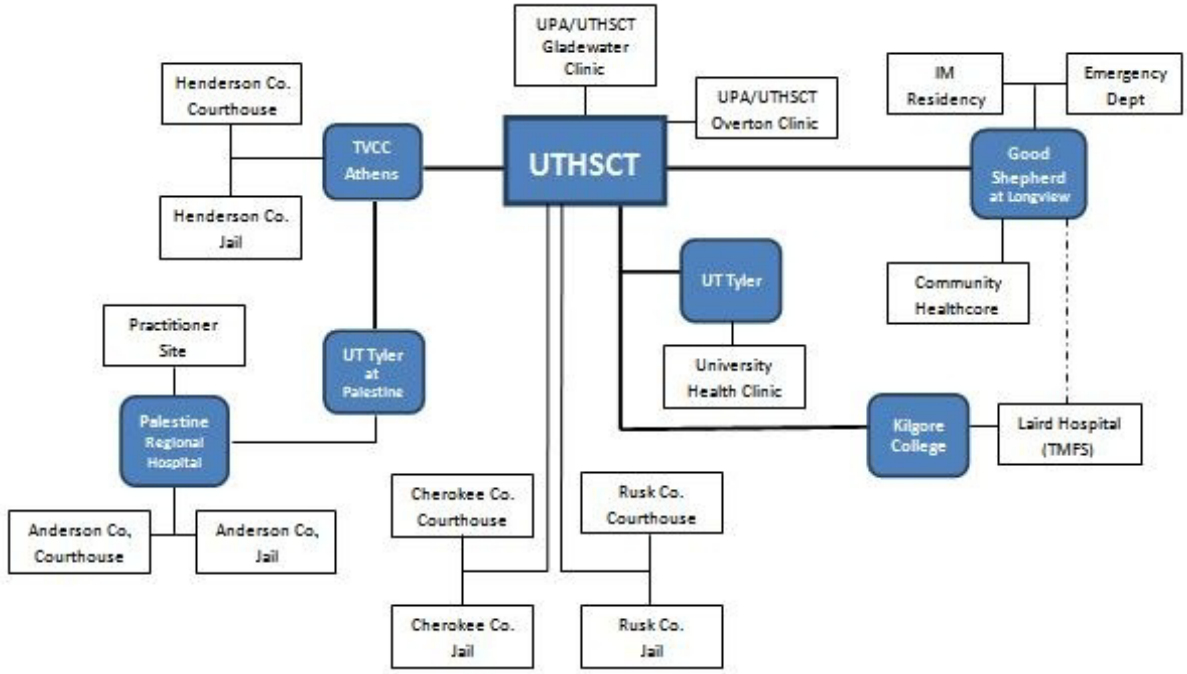
Challenges to accomplishing this goal will include insuring that program elements that are essential to development of a centralized and structured program, albeit a targeted and smaller one of this nature. (Meyer et al., 2012) These elements include telemedicine specific policies and procedures, medical record documentation, identification of and training for specialty providers, licensure/privileging, confidentiality, and facilitation of actual provider-patient encounters by trained “telepresenters” who are community health workers. UTHSCT/UPA have a track record in this area having established practice plan procedures dealing with matters such as medical records, privacy, credentialing, and scheduling. Other **challenges** include limited personnel resources in smaller rural clinic operations, and barriers to full implementation of electronic health records and integration with data collection systems which will permit bidirectional communication between providers. The project will overcome these challenges by assessing these issues early and developing a plan to address them. Additionally, qualified behavioral health providers and other relevant participants will be trained on processes, guidelines, and technology which will optimize use of the network. Encounters will be tracked and data collection conducted to evaluate success of the enterprise.

The **expected outcome** by the conclusion of the project in DY5 will be to improve the infrastructure for delivery of mental health services in this rural and vulnerable population. This will also result in performance achievement of a Category 3 intervention target intended to optimize the right care for the right setting and reduce admissions/readmissions to criminal justice settings.

Starting Point/Baseline: The **clients to be served** by this telemental network are drawn from the population of individuals with behavioral health needs in multiple rural counties (see above) currently served by UPA/UTHSCT and its primary care clinics (both internally and externally in Gladewater and Overton), Palestine Regional Medical Center, and Good Shepherd Medical Center and its affiliates. A separate DSRIP project is proposing a crisis intervention unit in Kilgore, Texas and a telemental network as proposed here could serve that initiative as well. However, at the present time, there are currently no substantive or organized efforts to develop regional infrastructure for this purpose. None-the-less, a network hub and framework with **high speed broadband communications technology** exists (see Fig. 1) and could be expanded and enhanced within the scope of this proposal to achieve the articulated goals and outcomes. The project will address the aforementioned challenges by assessing these issues early, developing a plan, and

conducting training for qualified behavioral health providers and other relevant participants during DY2 and DY3. During this same timeframe a **baseline** of **clients served** will be established for assessment of intervention targets in DY4 and DY5.

Fig. 1 - UPA/UTHSCT Telemental Infrastructure for Behavioral Health



Rationale: Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. There are nearly 1.5 million Texans who reside in this corner of the state. The region has higher numbers of uninsured residents with 54 percent of these Texans either uninsured or enrolled in some form of publicly funded insurance. The region is more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. Metropolitan counties account for just 46 percent of the region's population compared with 87 percent for all Texas residents. (Combs, 2008) Nearly 90 percent of the 28 counties in Region 1 (all except for three) are considered Primary Medical Care Health Professional Shortage Areas (U. S. Health Resources Services Administration).

In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. Findings of this assessment revealed higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. (Texas DSHS, 2007) DSHS estimates that over 85,000 individuals in the region have a serious mental illness, with well over 100,000 needing treatment for alcohol/drug use.

As is the case at the national level, these unmet needs stem, in part, from a dearth of behavioral health care providers throughout the state. (Texas HHSC, 2012) Texas has high rates of uninsured and those with behavioral health disorders are disproportionately affected. The rural

nature of the East Texas population combined with large travel distances only compound the limited access to behavioral health services for poor and vulnerable groups in this region of the state where provider ratios are five to ten times as high as for primary care. This access concern supports the rationale for selecting DSRIP **project options** 1.11.1 and 1.11.2 to "procure and build the infrastructure" for a telemental project and to "implement technology-assisted behavioral health services from … qualified providers." This project will fall within **Community Need** 2 (CN.2, insufficient access to mental and behavioral health services) and represents **a new initiative**.

Implementing technology-assisted services to support and coordinate behavioral health services will be achieved through a series of steps to incorporate **core project components** as specified in Category 1 of the RHP Planning Protocol (Texas HHSC, 2012) as follows:

- Assess the existing infrastructure for **high speed broadband communications technology** and the local availability/need for video communication equipment, and develop a **plan** for enhancing and adapting the current telehealth/tele-education network for delivery of telemental services
- Develop or adapt protocols to deal with matters such as medical records, privacy, credentialing, and scheduling
- **Train** qualified behavioral health providers, resident physicians, and other relevant participants on processes, guidelines, and technology which will optimize use of the network
- Track encounters to establish a baseline and collect data to assess intermediate outcomes relative to access
- Conduct **quality improvement** activities such as Plan-Do-Study-Act (PDSA)
- Extend a telemental connection between provider and criminal justice systems to promote right care in the right setting; assess impact on patient experience outcomes

The Telemental Infrastructure will use two basic interfaces with the endpoints. For patient and courtroom locations, the sites will use an individual video scenario, good for private viewing or by small groups of up to five. The larger educational sites, supporting from eight to sixty viewers, will be installed at Good Shepherd Medical Center's residency training classroom, at Palestine Regional Hospital, and at the Community Healthcore location in Longview. The larger sites will include improved sound systems and one or more 50" or larger high definition monitors.

Sites will be connected by a HIPPA-secured encrypted network running, where available, over cable modems allowing network speeds sufficient for high definition video. More remote sites will use dedicated lines of 10 - 50 megabits per second, again allowing high definition video. Where appropriate and needed, subsidized connections utilizing support from the Federal Communications Commission's Rural Health Initiative may be put into place in order to lower the cost to the project. The networking hub and video bridge infrastructure based at UTHSCT's NETnet facility will be upgraded to provide support for the classroom sites and to allow for interconnectivity with NETnet's additional locations.

Related Category 3 Outcome Measure(s): Process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to assess existing infrastructure, develop protocols and train personnel as outlined above. These include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort. In DY4 and DY5, a single standalone measure is selected from the domain Right Care, Right Setting (OD-9). Specifically, this will be IT-9.1, Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. **Evidence**

suggests that “interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.” (Texas HHSC, 2012, p. 405) This project will add a unique component to management of behavioral crises patients by facilitating combined medical as well as societal evaluation of individuals when questions of management location arise. The proposed network will extend a telemental connection between provider and criminal justice systems so that such determinations might be made more appropriately, readily, and efficiently and when a direct interaction is necessary prior to patient transportation. The ultimate **focus** of this intervention in **Region 1** is to **improve health outcomes of the lower income populations** that are disproportionately affected.

Relationship to other Projects:
As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure and educational expertise to benefit the following RHP project(s).
127278302.1.4 – Increase Training of Primary Care Workforce; Capacity Building through Workforce Development: Training Community Health Workers (CHWs)
127278302.2.18 Pass 3b (127278302.2.7)– Integrate Primary and Behavioral Health Care Services

The project could also have implications for **Category 4** measures such as patient-centered health care, patient satisfaction, and potentially preventable admissions and re-admissions.

Relationship to Other Performing Providers’ Projects in the RHP: UPA/UTHSCT will collaborate with multiple other acute care and mental health providers in the region **as noted earlier in this proposal.**

Plan for Learning Collaborative: UTHSCT houses The Northeast Texas Center for Rural Community Health (The Center). The Center was established for the purpose of: 1) engaging in community health service activities within the Northeast Texas region and 2) enhancing, promoting, coordinating, and supporting faculty and student projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. Specific roles of the Center will be to: 1) convene internal and external stakeholders who will participate in Regional Health Plan development and facilitation; 2) facilitate Regional Health Plan meetings and communicate function and purpose of the Regional Health Plan; 3) assist with identification of community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project; 4) coordinate efforts within the Regional Health Plan including provision of a platform and process for identifying, improving, and facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence; 5) serve as a point of contact for the Regional Health Plan with Texas Health and Human Services; 6) lend scholarly and academic assistance to the design and implementation of DSRIP projects. Serving as a facilitator for regional data transmission will be a key function of the Center, tied closely to evaluation of its success. UTHSCT will participate in a RHP-wide learning collaborative with other providers through the Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: East Texas experiences high levels of behavioral health morbidity and the rural uninsured populations remain disproportionately affected. There continues to be limited access to behavioral health services for poor and vulnerable groups in this region. Cycling through criminal justice systems is often tied to poor mental health outcomes and high costs to society. This project is intended to expand and enhance the infrastructure necessary to build targeted telemental/telehealth capacity within the Northeast Texas region, spanning multiple rural counties, and partnering with their respective healthcare providers. Modern communications technology is felt to hold considerable promise for filling gaps in access for behavioral healthcare delivery. Following an assessment of existent infrastructure, a plan will be devised for enhancing technical capabilities and connectivity, and implementing protocols, training, and quality improvement methods for effective delivery of care services. Use of Category 3, evidence-based measures will demonstrate improvement in outcomes tied to Right Care in the Right Setting. This infrastructure investment will help to reduce the financial burden to the regional health care system through provision of care in the appropriate setting and reduced utilization of high cost services such as emergency department visits and unnecessary hospitalization. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing CN.2, insufficient access to mental and behavioral health services.
- Enhanced access to behavioral health services for a rural/vulnerable population.
- Developing infrastructure which can increase access to high quality care.
- Building capacity through training of multiple providers and other related participants (CHWs) in the delivery and facilitation of telemental interactions.
- Providing a platform for integration of primary care and behavioral health as well as training for primary care residents.
- Reducing behavioral health morbidity resulting from cycling through the criminal justice system by providing Right Care in the Right Setting.
- Engagement of multiple large stakeholders in collaborative service delivery in Region 1.

References:

Association of American Medical Colleges (AAMC). AAMC physician workforce policy recommendations, September 2012. Available at: https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendations.pdf (last accessed 10-06-2012).

Combs S. Texas in Focus: Upper East Texas, 2008. Available at http://www.window.state.tx.us/specialrpt/tif/uppereast/ (last accessed 10-04-2012).

Institute of Medicine. Quality through collaboration: the future of rural health. Washington, D.C.: The National Academies Press, 2005, 288 pp. Available at http://www.nap.edu/catalog/11140.html (last accessed 10-01-2012).

Meyer BC, Clarke CA, Troke TM, Friedman LS. Essential telemedicine elements (tele-ments) for connecting the academic health center and remote community providers to enhance patient care. *Academic Medicine* 2012, 87(8):1032-1040.

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10-04-2012).

Texas Health and Human Services Commission (HHSC). Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

127278302.1.10 Pass 3b (127278302.1.3)	***1.11.1*** ***1.11.2***	***1.11.1.A-C*** ***1.11.2.A-H***	Implement technology-assisted services to support, coordinate, or deliver behavioral health services	
University Physician Associates				*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.35 Pass 3b (127278302.3.5)*	*3.IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 *P-5*: Procurement of Broadband Connection Metric 1 *P-5.1*: Documentation of presence of active broadband connection Baseline/Goal: Expand current capability Data Source: Demonstration of equipment Milestone 1 Estimated Incentive Payment (*maximum amount)*: $781,494 **Milestone 2** *P-4*: Procurement of tele- equipment Metric 1 *P-4.1*: Inventory of new equipment purchased Baseline/Goal: Expand current capability Data Source: Review of inventory or receipts Milestone 2 Estimated Incentive Payment (*maximum amount)*: $781,494	**Milestone 3** *P-8*: Training for providers/peers/residents/others on use of equipment Metric 1 *P-8.1*: Documentation of completion of training Baseline/Goal: New training Data Source: Training roster Milestone 3 Estimated Incentive Payment: $282,599 **Milestone 4** *P-9*: Development of manual of telemedicine/ telehealth with protocols/ guidelines Metric 1 *P-9.1*: Documentation of completion of manual and use in training Baseline/Goal: New manual Data Source: Operations manual with written protocols and guidelines Milestone 4 Estimated Incentive Payment: $282,599 **Milestone 5** *I-15*: Satisfaction with telemental services Metric 1 *I-15.1*: % of consumer/peer/provider surveys indicating satisfaction Goal: Establish baseline Data Source: Survey results		**Milestone 6** *I-15*: Satisfaction with telemental services Metric 1 *I-15.1*: % of consumer/peer/provider surveys indicating satisfaction Goal: Increase by 5% over baseline Data Source: Survey results Milestone 6 Estimated Incentive Payment: $601,306	**Milestone 7** *I-15*: Satisfaction with telemental services Metric 1 *I-15.1*: % of consumer/peer/provider surveys indicating satisfaction Goal: Increase by 10% over baseline Data Source: Survey results Milestone 7 Estimated Incentive Payment: $648,387 Number of people potentially served in DY5 = 9,357 Volume of service anticipated in DY5 = 677

127278302.1.10 PASS 3B (127278302.1.3)	***1.11.1*** ***1.11.2***	***1.11.1.A-C*** ***1.11.2.A-H***	Implement technology-assisted services to support, coordinate, or deliver behavioral health services	
University Physician Associates				*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.35 Pass 3b (127278302.3.5)*	*3.IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5 Estimated Incentive Payment: $282,599			
Year 2 Estimated Milestone Bundle Amount: $1,562,988	Year 3 Estimated Milestone Bundle Amount: $847,797		Year 4 Estimated Milestone Bundle Amount: $601,306	Year 5 Estimated Milestone Bundle Amount: $648,387
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $3,660,478				

Project Option: 1.2.2 – Increase Training of Primary Care Workforce
Unique Project ID: 127278302.1.4 (Pass 1)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center Tyler (UTHCT) sits on a 614 acre site northeast of Tyler Texas. In 1977, the institution joined the University of Texas System, with a primary three-fold mission to conduct patient care, research, and education in the treatment of pulmonary and heart disease. Currently, the academic center consists of a 109 bed hospital with over 20 outpatient clinics and 30 areas of specialty, including adult and pediatric pulmonary and infectious disease, cardiology, oncology, family practice and internal medicine, occupational medicine, asthma, allergy, lung disease, diabetes, aging, and gastroenterology.
Intervention(s): Working collaboratively with the East Texas Health Education Center (AHEC) and the Department of Labor, UTHSCT will become a certified apprenticeship and continuing education location for training and deploying CHWs. UTHSCT's goal is to train and certify more CHWs to be deployed into Region 1 to support disease prevention measures, provide peer support to improve self management, and monitor target populations for early detection of risk for decomposition.
Need for the Project: The region has a higher than average prevalence of certain chronic diseases, and admission rates for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and mortality rates from heart disease and chronic lung disease are among the highest in the state. UTHSCT expects to improve health quality for patients with chronic disease and behavioral health care needs, decrease in preventable admissions/readmissions, an increase in self management skills among the target populations, and increase the primary care workforce by expanding the number of certified working CHWs in Region 1.
Target Population: The majority of counties in Northeast Texas also have higher rates of preventable hospitalizations for pneumonia, congestive heart failure, high blood pressure, asthma, COPD, and diabetes compared to the rates for Texas. Further, it was estimated that over 85,000 individuals regionally have a serious mental illness, with well over 100,000 needing treatment for alcohol/drug use. The CHW training program will increase the primary care workforce in region 1, and provide services to region 1's population identified above as high risk for chronic disease, behavioral health needs, and inappropriate ED utilization.
Category 1 or 2 Expended Patient Benefits: The CHW training program will seek to expand primary care training in DY 2; hire and train 10 CHW instructors in DY 3; increase the number of certified CHWS to ~~36~~ 50 in DY 4; and increase the number of CHW's working in performing providers facilities to add 6 DOL locations in DY 5.
Category 3 Outcomes: After completing project planning and establishing baseline rates in DY 2, ~~IT-9.4 will be implemented which is to increase the number of DSHS certified CHW's whom are working in region 1 in chronic disease management and/or behavioral health throughout DY 3 to DY 5.~~ IT-1.11 will be implemented which is to control BP (<140/80mm Hg) among diabetic and high risk patients residing in region 1; with a goal of BP compliance increase throughout DY

3 to DY 5. Percentage of increase will be determined following the establishment of baseline rates in DY 2.

Project Description: Working collaboratively with the East Texas Health Education Center (AHEC) and the Department of Labor, UTHSCT will become a certified apprenticeship and continuing education location for training and deploying CHWs. UTHSCT's goal is to train and certify more CHWs to be deployed into Region 1 to support disease prevention measures, provide peer support to improve self-management, and monitor target populations for early detection of risk for decomposition. The **goal** of UTHSCT is to: 1.) increasing the number of CHWs working within Region 1 with specific target population education and training. All CHWs will complete the DSHS approved CHW curriculum with additional basic training in the areas of behavioral health, primary care, tele-health, the chronic care model and case management. In addition, CHWs will then go through a specialty track in either; behavioral health, primary care, or tele-health which will provide in depth training and will prepare the CHW for deployment and hire within open positions throughout the region. 2) providing early intervention in behavioral health populations to prevent unnecessary use of services in settings such as ER's, urgent care, and the criminal justice centers. CHWs that receive specialty training in behavioral health will be utilized to provide home visits and ensure patients are receiving timely access to care and are receiving early intervention during times of crisis. Partnerships with behavioral health clinics, centers, and providers will ensure the sustainability of the CHW. 3) reducing behavioral health potentially preventable admissions/readmissions through increasing coaching on self-management and health literacy. 4) optimizing wellness and healthcare utilization by providing peer support and identifying early non-compliance of chronic health conditions and notifying medical home team for appropriate follow-up. CHWs who receive specialty training in primary care will be utilized to provide a constant link between the provider and the patient. Partnerships between home health agencies within the region will ensure the sustainability of these CHWs. Currently, four home health agencies within the region have agreed and signed letters of support for this project.

CHWs will also play an integral role in providing access to primary care and specialty care services through Tele-Health capacity. CHWs will link patients from the medical home to the healthcare provider through Tele-Health services. UTHSCT will work to provide the Department of State Health Services approved CHW curriculum for training of new CHWs and to provide continuing education opportunities for both certified CHWs and certified CHW instructors. Curriculum will have an emphasis on topics recommended for disease prevention and health education by Healthy People 2020, including the new additions genomics, life quality and well-being, and adolescent and child health. In addition, to meet the needs of Region 1, curriculum will also be developed focusing on behavioral health to help provide an early intervention for targeted behavioral health populations.

The East Texas Health Education Center (AHEC) is already an established CHW training provider with the DSHS. UTHSCT will seek to become a certified continuing education location for training CHWs through DSHS with a partnership with AHEC. CHWs and CHW instructors are required to complete 10 hours of continuing education annually; UTHSCT will provide this service while providing education/training on topics specific to target populations within region 1. UTHSCT will also work with sites within the region and the department of labor (DOL) to help sites gain CHW apprenticeship status. There is no cost to the sites to become an apprenticeship

site and many incentives are offered to the site for becoming an apprenticeship location. Apprenticeship sites receive wage tax credits, are eligible to apply for category 133 funds to subsidize the costs of apprenticeship positions, and once registered as a site has access to funding under the workforce investment act (WIA). All apprenticeship sites will have a DOL field representative assigned to them at no cost to help the site with the regulatory standards that need to be met and with accessing their incentives. These incentives and support greatly enhances the sustainability of the CHW training and deployment initiatives of the project. After the apprenticeship ends, the site will have the option through support with WIA funds to hire the CHW in a permanent position. However, if the site chooses not to hire the CHW permanently the CHW will then be rerouted to an open CHW position within one of the other interrelated projects as described below.

There are **challenges** to accomplishing this goal. Becoming a Department of Labor Apprenticeship site requires a commitment by the business location hosting the opportunity. There are 22 standards which the location must meet in order to be a registered apprenticeship site. These standards will require time and effort by the business location. However, the design of the proposed CHW training model will provide a capacity building and infrastructure for support, to address this challenge and help provide access to administrative workforce development liaisons and Department of Labor field representatives that can assist with these transitions.

The first step in creating a successful CHW training program is to train and recruit CHW instructors within Region 1. During DY2, UTHSCT intends on training 10 CHW instructors who will be housed throughout Region 1. The geographical locations of CHW instructors is important, for they will be training and helping place CHW students within their localized area. Throughout DY 3-5, UTHSCT will be offering 3 CHW training sessions annually and will be recruiting and deploying 13 students per session, leading to a total of 36 CHWs employed within Region 1 and a total of 50 CHW's trained. To ensure completion of CHW curriculum in full, CHW students will be required to put up a $100 deposit which will then be returned at the completion of the program. DY 4 and 5 along with training and deploying new CHWs will also be dedicated to training current CHWs in specialty areas needed within Region 1, including behavioral health, tele-health, and primary care with an emphasize in chronic care. The **expected outcome** is that UTHSCT intends to train 20 CHWs in behavioral health; 15 CHWs in tele-health; and 15 CHWs in primary care by the completion of DY 5.

Starting Point/Baseline: Prior research has shown that CHWs are effective in increasing knowledge and promoting behavior change, increasing improvement in utilization patterns, and reducing **ER visits, hospital admissions/readmissions** and **total patient costs**. The East Texas AHEC became a CHW training site in the fall of 2010. Since that time East Texas AHEC has trained 14 CHWs within Region 1. Utilizing the Department of Labor's Apprenticeship program and the current training site at East Texas AHEC; UTHSCT proposes to expand the CHW program to incorporate apprenticeship opportunities throughout Region 1, an updated modified curriculum that reflects the needs of the target population, and provide the capacity to increase the number of **trained certified CHWs** and **CHW instructors** within Region 1.

Rationale: UTHSCT expects a improve health quality for patients with **chronic disease** and

behavioral health care needs, decrease in **preventable admissions/readmissions**, an increase in self management skills among the target populations, and increase the **primary care workforce** by expanding the number of certified working CHWs in Region 1.

According to the U.S. Census Bureau, the population of Texas exceeded 25 million in 2010. Not unlike the rest of the country, Texas is plagued by the rising cost of health care, largely attributable to chronic diseases which account for 3 in 4 deaths. (Combs, 2008) Unhealthy behaviors (poor nutrition, tobacco use, inactivity) are important influences. In 2009, two-thirds of all adult Texans were overweight or obese. (Combs, 2011) Upper East Texas is much more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. (Combs, 2008) The region has a higher than average prevalence of certain chronic diseases, and **admission rates** for **chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)**, and mortality rates from **heart disease** and chronic **lung disease** are among the highest in the state (Combs 2008; Jackson, Suzuki et al. 2011). The population is 71 percent white, 15.6 percent black, and 11 percent Hispanic. Hispanics are among the fastest growing segment. Roughly one-fourth of the region's counties are considered to be health professional shortage areas; costs to the region's hospitals alone due to **heart disease**, **congestive heart failure,** and stroke in 2005 approached $700 million. (Combs, 2008)

In 2007, the Texas Department of State Health Services (DSHS) undertook an East Texas community health needs assessment (ETCHNA) to document the scale of health issues in the region. (Texas Department of State Health Services 2007) This region of nearly 1.5 million population corresponds to the same 35 county service area of Northeast Texas from which the University of Texas Health Science Center at Tyler (UTHSCT) and its clinics draw their current active patient base.

Demographic and epidemiologic information obtained from the ETCHNA indicates a smoking prevalence of nearly 27 percent compared with a state rate of 20 percent, higher regional rates of inactivity, and higher rates of high blood pressure in African Americans, whites, and Hispanics. Notably, the majority of counties in Northeast Texas also have higher rates of **preventable hospitalizations for pneumonia, congestive heart failure, high blood pressure, asthma, COPD,** and **diabetes** compared to the rates for Texas. Further, it was estimated that over 85,000 individuals regionally have a serious **mental illness,** with well over 100,000 needing treatment for **alcohol/drug** use.

The CHW training program will meet the community needs by addressing community need number (CN.1) insufficient access to primary and specialty health care services; (CN. 2) insufficient access to mental/behavioral health care services; (CN.3) high rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer; (CN.4) high costs due to potentially preventable hospital admissions/readmissions, and (CN.5) inappropriate emergency department utilization.

Related Category 3 Outcome Measure(s): DY 2 is comprised of two process milestones. The first process milestone is P-1 Project Planning which will consist of engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. The second process milestone is P-2 Establishing Baseline Rates in which the CHW program administration will work to establish and then report baseline numbers of the number of CHWs who achieve DSHS certification, and become employed in chronic health and/or behavioral health in Region 1.

DY 3 is comprised of one process milestone and one outcome improvement target. The process milestone is P-3, the development and testing of data systems that will hold data and help with reporting of CHW certification and employment status. The outcome improvement target, IT-9.4, will measure the CHW graduates DSHS certification rate and employment status compared to baseline established in DY 2 among current CHWs residing in Region 1.

DY 4 is comprised of a single outcome improvement target, I~~T-9.4, which will measure the CHW graduates DSHS certification rate and employment status compared to baseline established in DY 2 among current CHWs residing in Region 1.~~ IT-1.11, which will strive to control BP (<140/80mm Hg) among diabetic and high risk UTHSCT CHW patients residing in region 1; with a goal of BP compliance among patients 18 to 75 years of age whom as of the end of the measurement year has been diagnosed with diabetes or whom are at high risk for diabetes. Percentage of increase of compliance will be determined following the establishment of baseline rates in DY 2.

DY 5 is comprised of a single outcome improvement target, ~~IT-6.1, which will measure the CHW graduates DSHS certification rate and employment status compared to baseline established in DY 2 among current CHWs residing in Region 1.~~ IT-1.11, which will strive to control BP (<140/80mm Hg) among diabetic and high risk UTHSCT CHW patients residing in region 1; with a goal of BP compliance among patients 18 to 75 years of age whom as of the end of the measurement year has been diagnosed with diabetes or whom are at high risk for diabetes. Percentage of increase of compliance will be determined following the establishment of baseline rates in DY 2.

Rationale for Outcome Measures: As stated above in the rationale, the region has a higher than average prevalence of certain chronic diseases, and admission rates for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and mortality rates from heart disease and chronic lung disease are among the highest in the state. The majority of counties in Northeast Texas also have higher rates of preventable hospitalizations for pneumonia, congestive heart failure, high blood pressure, asthma, COPD, and diabetes compared to the rates for Texas. Further, it was also estimated that over 85,000 individuals regionally have a serious mental illness, with well over 100,000 needing treatment for alcohol/drug use. Prior research has shown that CHWs are effective in increasing knowledge and promoting behavior change, increasing improvement in utilization patterns, and reducing ER visits, hospital

admissions/readmissions and total patient costs. By implementing the category 1 project-Increasing Training of the Primary Care Workforce; the category 3 metrics of increasing the number of DSHS certified CHWs working in chronic or behavioral health in Region 1 and increasing BP compliance among diabetic patients can be achieved.

Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure and educational expertise to benefit the following RHP project(s): 127278302.1.10 Pass 3b (127278302.1.3) Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavioral Health Services in Northeast Texas: CHWs will be trained to work and demonstrate the use of tele-health equipment; this will allow CHWs to visit patients in their home and help connect the patient to the provider through tele-health services. 127278302.1.9 Pass 3b (127278302.1.2) Improve Access to Specialty Care: CHWs will provide a link from the patient to the nurse navigator on the patient's medical home team. The CHW will provide peer to peer support for the patient and ensure the patient is receiving access to the provider in a timely and efficient manner. 127278302.2.18 Pass 3b (127278302.2.7) Integrate Primary and Behavioral Health Services: CHWs will provide home visits to ensure the behavioral health patient is receiving timely access to care and receives treatment prior to crisis. 127278302.2.5 Evidence-Based Disease Prevention Expand Delivery of Early Colon Cancer Treatment and Secondary Prevention Management: CHWs will provide peer to peer patient education and support to enhance health literacy and increase cancer screening among high risk populations. 127278302.2.19 Pass 3b (127278302.2.8) Implement Patient Care Navigator and CHW Chronic Disease Self-Management Program to Reduce Emergency Department Visits: CHWs will play an integral part in connecting the patient to the nurse navigator in the patient centered medical home (PCMH). 127278302.2.16 Pass 3b (127278302.2.4) Improve Self-Management for Pediatric Asthma Patients: CHWs will serve as asthma coach's year around to reinforce trigger control and medication recommendations for populations targeted by the asthma mobile unit project.

Relationship to Other Performing Providers' Projects in the RHP: Working with Christus St. Michael's, Good Shepherd Medical Center, and Community Health Core, there will be a collaborative effort to increase primary care capacity. UTHSCT will serve as the training site for CHWs and the partner organizations listed will serve as apprenticeship sites with possible permanent hiring employment beyond apprenticeship.

Plan for Learning Collaborative: The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health (The Center). The Center was established for the purpose of: 1) engaging in community health service activities within the Northeast Texas region and 2) enhancing, promoting, coordinating, and supporting faculty and student projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. Specific roles of the Center will be to: 1.) convene internal and external stakeholders who will participate in Regional Health Plan development and facilitation; 2.) facilitate Regional Health Plan meetings and communicate function and purpose of the Regional Health Plan; 3.) assist with identification of community needs, the projects and investments under DSRIP to address those

needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project; 4.) coordinate efforts within the Regional Health Plan including provision of a platform and process for identifying, improving, and facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence; 5.) monitoring outputs, metrics, and intermediate outcomes, coordinating data, and reporting on the progress of the Regional Health Plan; 6.) serve as a point of contact for the Regional Health Plan with Texas Health and Human Services; 7.) lend scholarly and academic assistance to the design and implementation of DSRIP projects. Serving as a facilitator for regional data transmission will be a key function of the Center, tied closely to evaluation of its success. UTHSCT will participate in a RHP-wide learning collaborative with other providers through the Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: Rural underserved populations continue to carry the heaviest burden of both a primary care workforce and specialist shortage. Infrastructure investment in this project is intended to improve access to primary and specialty care within Region 1. Assessment of the gaps in primary care and specialty services and implementation of a plan to increase targeted primary and specialty access will help to create an efficient access to a care system which will result in the right care in the right setting. Use of Category 3, evidence-based outcome measures which rely upon the increase in primary care workforce; specifically the CHW; are intended to improve access to care and ensure appropriate care utilization. Taken together, these benefits will help to reduce the financial burden to the regional health care system through early detection and management of disease, reduced morbidity, and reduced utilization of high cost services. The value of this project is justifiable on the basis of:

- Addressing CN.1, insufficient access to primary and specialty health care, by enhancing access to primary care and specialty care services for a rural/vulnerable population and to promote early intervention measures.
- Improved coordination of care resulting in more timely delivery and better compliance with recommended improvement targets.
- Building capacity and sustainability through process development, training and recruitment of CHWs, and training of CHWs in appropriate referral procedures and chronic and behavioral health interventions.

References:

Combs,S.(2008). “Texas in Focus: Upper East Texas.” Retrieved 12/30/2011, From http://www.window.state.tx.us/specialrpt/TIF/

Combs, S. (2011). “Gaining Costs Losing Time 2011 Special Report: The Obesity Crisis in Texas” Retrieved 12/30/2011, From http://www.window.state.tx.us/specialrpt/obesitycost/

Jackson, B.E., S. Suzuki, et. al. (2011) “Geographic Disparity in COPD Hospitalization Rates Among the Texas Population” Respir. Med. **105** (5): 734-739

Texas Department of State Health Services (2007). East Texas Community Health Needs Assessment: 117

127278302.1.4	***1.2.2***	***1.2.2***	Increase Training of Primary Care Workforce	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	*127278302.3.6*	*3.IT-~~9.4~~ 1.11*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Expand Primary Care Training – *P-2*: Metric 1 Expand primary care clinician/staff training programs – *P-2.1:* Baseline/Goal: Documentation of applications and agreements to expand training programs Data Source: Training Program Documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,009,780	**Milestone 2** Expand Primary Care Training - *P-2*: Metric 1 Hire Additional Precepting Primary Care Faculty-*P-2.2*: Baseline/Goal: Increase number of additional training faculty/staff – 10 CHW Instructors Data Source: HR documents and faculty lists Milestone 2 Estimated Incentive Payment: $ 558,838 **Milestone 3** Expand Positive Primary Care Exposure for Trainees - *P-3*: Metric 1 Train trainees in the medical home model, chronic care model and to participate in medical homes- P-*3.2*: Baseline/Goal: Documentation of Program Data Source: Curriculum, rotation hours, and patient panels assigned to trainee. Milestone 3 Estimated Incentive Payment: $ 558,838		**Milestone 4** Increase Primary Care Training and Rotations - *I-11*: Metric 1 Increase number of primary care trainees as measured by percentage of change over baseline – *I-11.1*: Goal: Increase the number trainees enrolled in primary care training programs -~~36~~ 50 CHWs Data Source: Documentation of class enrollment by year by primary care training program Milestone 4 Estimated Incentive Payment: $ 1,061,278	**Milestone 5** Recruit/hire more trainees to primary care positions in performing providers facilities - *I-12*: Metric 1 Percentage of change in number of trainees accepting positions in the performing providers facilities over baseline - *I-12.1*: Goal: Increase the number of graduates accepting positions in the facility out of those who received training at the facility. 6 DOL Locations Data Source: HR documentation compared to class lists Milestone 5 Estimated Incentive Payment: $ 928,618
Year 2 Estimated Milestone Bundle Amount*:* $ 1,009,780	Year 3 Estimated Milestone Bundle Amount: $ 1,117,677		Year 4 Estimated Milestone Bundle Amount: $ 1,061,278	Year 5 Estimated Milestone Bundle Amount: $ 928,618
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 4,117,353				

Project Option: 1.1.1 - Expand Primary Care Capacity
Unique Project Identification Number: 127278302.1.11 Pass 3b (127278302.1.5) (Pass 1)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider: With support from the regional academic medical center, University of Texas Health Science Center at Tyler, this project will be implemented by CHRISTUS ST. Michael Health System which is a 312-bed acute hospital that serves Texarkana, USA for the benefit of its patient population that draws from a radius of approximately 50 miles.
Intervention(s): This project will implement a Federally Qualified Health Center in partnership with Genesis PrimeCare to provide primary care for the Medicaid, Medicare, and indigent patient population.
Need for the project: Between July 2009 and February 2012 CSM has had approximately 15,000 patient encounters in the emergency department that were categorized as non-emergent (levels 1 & 2). 72% of all visits in those categories came from patients that were self-pay or Medicaid.
Target population: The target populations are the community members with Medicaid and no health coverage that need access to a primary care provider instead of using the emergency room. The clinic is projected to have 35,000 encounters over the next three years.
Category 1 expected patient benefits: The project seeks to provide a cumulative of approximately 35,000 patient visits by DY5 (DY2 – 8,000, DY3 – 8,800, DY4 – 9,200, DY5 – 9,600).
Category 3 outcomes: IT-2.11 Our goal is to reduce the Ambulatory Care Sensitive Conditions Admissions Rate from 0.468% currently (SFY12) to 0.433% by DY5.
Project Description: The goal of this project is to increase CHRISTUS St Michael Health System's (CSM) ability to provide appropriate care in a timely manner in the proper setting which is directly in line with the regional goal of increasing access to health care services. The major delivery system solution proposed is to increase primary care capacity by increasing the number of primary care clinic appointments available to the low-income members of the community and in doing so, creating more access. It is important that CSM creates more access to primary care for the community by partnering with Genesis PrimeCare to establish a clinic with extended hours closer in distance to the constituents who had previous used the emergency department as a source of primary care. To substantially improve CSM's primary care capacity, as evidenced by a 20% increase in primary care encounters, approximately 35,000 visits over four demonstration years, at the newly established clinic, in DSRIP Year (DY) 5 compared to baseline (DY2). If broken out by year the estimated encounters would be as follows: DY2 – 8,000, DY3 – 8,800, DY4 – 9,200, DY5 – 9,600.

CSM's patient population, as many other hospital providers in North East Texas, has a high volume of patients that are low income and uninsured which are disproportionately medically disenfranchised. These individuals often have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute episodes putting patients at risk for extended hospitalizations, disability, and/or premature death. Clinic locations and cost of care can, at many times, discourage people from using health care proactively which will also negatively impact community members' health status. Long wait times in the emergency department have yet to discourage to practice of waiting to an illness occurs, mostly because it is the avenue of last resort. Changing patient behavior and will aid in the success of this project. The relationship formed in supporting this project does not duplicate another federal relationship - documentation is forth coming.

Starting Point/Baseline: CSM has seen a significant change to uninsured/charity in its payor mix since the economic downturn of 2008. As a result, many patients rely exclusively on CSM's emergency department for their healthcare needs; these settings are not designed to provide comprehensive assessment, preventive care, and/or care coordination. Between July 2009 and February 2012 CSM has had approximately 15,000 patient encounters that were categorized as non-emergent (Level 1 or 2 visit). 72% of all visits in those categories came from patients that were self-pay or Medicaid. The statistics and information provided in the RHP community needs assessment support that there is a need for more primary care, especially care that highly accessible and affordable

Rationale: Establishing an additional clinic(s) as a way of to expand primary care is of high priority to the organization and the foundation to other projects. The proposed location of the clinic will be closer to the community members who would receive the greatest benefit from additional access. Providing access to care with affordable follow-ups visits, especially for those with chronic conditions closely aligns with the mission of the organization "To Extend the Healing Ministry of Jesus Christ" by way of providing care to all with compassion and integrity regardless of socioeconomic status. Nearly 17% of Bowie county is at or below the federal poverty line, the clinic will be a great service to the citizens of Bowie county (and Miller County, Arkansas by way of patient flow) and will alleviate the pressure put on the emergency department that has been serving much of the population in the same fashion that a primary care clinic would serve. The milestones chosen associate a correlation to increased volumes to reduced volumes of self-pay in the emergency department. There has been a similar effect to the organization developing a walk-in clinic on the outskirts of the primary market which lead to decreased low-level ED visits from those zip codes. Overall, this project addresses community needs CN.1, CN.4, and CN.5 of the RHP.

Related Category 3 Outcome Measures: IT – 2.11 Ambulatory Care Sensitive Conditions Admissions Rate 127278302.3.36 Pass 3b (127278302.3.7)

Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care.

Relationship to other Projects: Project 127278302.1.11 Pass 3b (127278302.1.5) stands as a foundation to most of the projects supported by CSM in presented waiver. This project promotes the behavior of preventative primary care and with plans of making the clinic accessible from hours of operation and location standpoint. This project will support 127278302.1.12 Pass 3b (127278302.1.6) by creating a flow of traffic and referrals to the nearby practice, collaborate with the affiliated hospital (CSM) to enable the effectiveness of 127278302.2.20 Pass 3b (127278302.2.9) to manage patients with the hospital case management department, and further support the need to increase the amount specialist so members of the community can seek out specialty care from providers that are aligned with the goals of the clinic and hospital to furthers the goals of the RHP.

Relationship to Other Performing Providers' Projects in the RHP: Successes and lessons learned will be shared by other RHP members through the regional learning collaborative described below.

Plan for Learning Collaborative: The RHP Region 1 anchor will sponsor meetings and conferences to facilitate the opportunity for healthcare providers throughout the region and the state to share experiences, challenges, lessons learned and best practices. The leadership team for this project will actively participate in those opportunities.

Project Valuation: The initial cost of remodeling an existing building to serve as a clinic and the recruitment of a Physicians and Nurse Practitioners is an investment that will increase access to care, facilitate earlier referrals when additional care is needed and thereby reduce the financial burden to the regional health care system. Creating additional primary care capacity will lead to more timely initial appointments and a reduction of low acuity emergency department visits. In additional to the investment in physical infrastructure, there will be a need for additional office staff. By addressing community needs CN.1, CN.4, and CN.5 this project will be a strategic benefit to the health system, the RHP, and population of the Texarkana area.

127278302.1.11 PASS 3B (127278302.1.5)	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS***	
UPA				*127278302*
Related Category 3 Outcome Measure(s):	127278302.3.36 Pass 3b (127278302.3.7)	*IT – 2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Milestone: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Establish clinic and establish baseline. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider **Milestone 1** Estimated Incentive Payment: $1,477,189	**Milestone 2** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Baseline/Goal: Baseline established in DY2/ 10% growth in volume as compared to baseline Data Source: Registry/EHR **Milestone 2** Estimated Incentive Payment: $1,257,779		**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Baseline/Goal: Baseline established in DY2/15% growth in volume as compared to baseline Data Source: Registry/EHR **Milestone 3** Estimated Incentive Payment: $1,174,123	**Milestone** 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Baseline/Goal: Baseline established in DY2/20% growth in volume as compared to baseline Data Source: Registry/EHR **Milestone 4** Estimated Incentive Payment: $1,000,273
Year 2 Estimated Milestone Bundle Amount: $1,477,189	Year 3 Estimated Milestone Bundle Amount: $1,257,779		Year 4 Estimated Milestone Bundle Amount: $1,174,123	Year 5 Estimated Milestone Bundle Amount: $1,000,273
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,909,364				

Project Option: 1.8.6 The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.
Unique Project Identification Number - 127278302.1.12 Pass 3b (127278302.1.6) (Pass 1)
RHP Performing Provider/TPI: UTHSCT – MSDRP (University Physician Associates) 127278302

Project Abstract

Provider: With support from the regional academic medical center, University of Texas Health Science Center at Tyler, this project will be implemented by CHRISTUS ST. Michael Health System which is a 312-bed acute hospital that serves Texarkana, USA for the benefit of its patient population that draws from a radius of approximately 50 miles.
Intervention(s): This project will implement a dental clinic in partnership with Genesis PrimeCare to provide dental care for the Medicaid, Medicare, and indigent patient population.

Need for the project: In August 2011 CHRISTUS St. Michael Health System in conjunction with the Texas Dental Association's "Texas Mission of Mercy" sponsored a free two day dental clinic that treated 530 patients. The Texarkana region doesn't have a low income dental clinic for adults and as a result many members of the community don't receive necessary preventative care, especially those with special needs.

Target population: The target populations are the community members with Medicaid and no health coverage that need access to preventative dental care instead of using the emergency room. Our organization treated 698 "non-emergent" dental cases in the emergency department during SFY12.

Category 1 expected patient benefits: The project seeks to provide approximately 4,000 total dental encounters to ~~Medicaid~~ patients from DY2 – DY5. Broken out by year, the patients served are as follows: DY3 – 1,200, DY4 – 1,320, DY5 – 1,440.

Category 3 outcomes: IT-17.10 Our goal is to decrease the percentage of non-emergent (levels 1 & 2) emergency department visits for dental care from 10.2% currently (SFY12) to 9.18% by DY5.

Project Narrative

Project Description: To expand services to five groups that are underserved with regard to dental health problems. They are community members under 18 years of age without dental insurance or access to dental care, those with physical or emotional disabilities, citizens with other chronic conditions, pregnant women, and elderly persons with limited transportation. The primary care expansion proposed in Project 127278302.1.12 Pass 3b (127278302.1.6) will serve as the foundation that will allow a more appropriate setting for expanded dental health service to increase access for the identified "at-risk" population. This goal addresses the need to provide an appropriate access to treatment setting for persons suffering with dental problems. The project will reduce health problems resulting from improper or inadequate dental health care as well as provide patients with a "medical home" with primary care to eliminate or substantially improve care for chronic conditions which is aligned with the regional goals of improving the health of populations and reducing the costs of health

care. The expected outcome through DY5 is to increase dental encounters with at risk population by 20% over baseline (DY3).
Patients who present at the CHRISTUS St. Michael Health System (CSM) emergency department (ED) with primary or secondary dental health problems are overwhelmingly adults under 65 years of age who are either not categorically eligible for Medicaid or Medicare and have limited financial resources. These are patients who often have other medical complications that are exacerbated by the existence of the dental health problem. Patients affected by co-morbidity, chronic illness and without a medical home are frequently placed in a position where the only accessible care is in an acute hospital ED which is not designed to provide general dentistry. The patient is only able to receive symptomatic, short term relief that results in frequent repeat visits without dealing with the core problem. One of the challenges will be recruitment of a provider to care for this population as it is always challenging to recruit to this part of Texas. As well as find a location that is easily assessable via public transportation for individuals that do not have vehicles; the dental clinic will be a new clinic and not an expansion of an existing operation.

Starting Point/Baseline: In August 2011 CSM in conjunction with the Texas Dental Association's "Texas Mission of Mercy" sponsored a free two day dental clinic that treated 530 patients. Services provided included primary preventive services, tooth extraction and some partial plates. CSM could have easily served twice the number of patients if they had the facilities and staff available. Subsequent to the two-day event CSM has endeavored to work with people having dental health problems and limited resources who have resorted to accessing our ED for relief. The effort has shown benefits as well as demonstrated that an expanded and more integrated effort as part of a medical home strategy would result in increased access, reduced health care expenditure and improvement in the health and overall quality of life for patients.

Rationale: Poor oral health can cause these serious health problems - Heart disease, researchers have found that infection of the gum, can lead to coronary heart disease or atherogenesis, a condition in which plaque forms in your arteries. Stroke, if you are missing some or all of your teeth, or have lost significant amounts of bone and tissue around your teeth, you may be at increased risk of stroke. Diabetes, Researchers have discovered that periodontal disease somehow affects the body's metabolism and can contribute to the development of pre-diabetes, a condition in which blood glucose levels are higher than normal. Pregnancy complications, research by the American Academy of Periodontology has shown that periodontal disease can increase the risk of delivering a pre-term baby with a low birth weight. Kidney disease, Poor oral health also seems to be linked to chronic kidney disease, which affects blood pressure and bone health, and can lead to kidney failure and heart disease. Mental health problems, it is common knowledge that stress and anxiety can impact your health. But research has now shown a strong relationship between oral disease and many mental health problems, including stress, depression, distress, anxiety, and loneliness.

Special needs patients-particularly adults with developmental disabilities. These are patients who are generally covered under Medicaid for which there is very limited coverage and practically nothing for preventive and or routine ameliorative services. People with special needs are those whose dental care is complicated by a physical, mental, or social disability. They have tended to receive less oral health care, or of lower quality, than the general population, yet they may have oral problems that can affect systemic health.

The ADA says "Oral health care in pregnancy is often avoided and misunderstood by physicians, dentists, and patients." Evidence-based practice guidelines are still being developed. Research suggests that some prenatal oral conditions may have adverse consequences for the child. Periodontitis is associated with preterm birth and low birth weight, and high levels of cariogenic bacteria in mothers can lead to increased dental caries in the infant. Other oral lesions, such as gingivitis and pregnancy tumors, are benign and require only reassurance and monitoring. Every pregnant woman should be screened for oral risks, counseled on proper oral hygiene, and referred for dental treatment when necessary.

This project represents a new initiative by CSM and Genesis PrimeCare as we attempt to provide more capacity for ongoing health care services in addition to Texas Mission of Mercy dental events. Community needs addressed are CN.1, CN.4, and CN.5 of the RHP and a baseline will be established in DY2.

Related Category 3 Outcome Measures: Decrease the percentage non-emergent emergency department visits for dental care 127278302.3.37 Pass 3b (127278302.3.8)
States can reduce or contain dental costs in the emergency department setting by making better use of proven forms of prevention, improving access by expanding the number of dental practitioners and expanding access to dental education. When so many people seek care at hospitals for preventable dental problems, it wastes taxpayer dollars. Investing more in prevention and ensuring access to treatment can save money by reducing the incidence of untreated decay and other dental ailments.[46] Because of the high number of dental cases, 698 in levels 1 and 2, the organization treated in the emergency department during SFY12, CSM felt this would be an appropriate measure to track success of the newly established clinic for the targeted patient population.

Interrelated projects: This project serves as an extension of 127278302.1.11 Pass 3b (127278302.1.5) to expand access to primary care with similar aims of focusing on preventative care through the specialty of dentistry. This project can also been seen as a component of 127278302.2.20 Pass 3b (127278302.2.9) as it becomes an arm of the medical home.

Relationship to Other Performing Providers' Projects in the RHP: Successes and lessons learned will be shared by other RHP members through the regional learning collaborative described below.

Plan for Learning Collaborative: The RHP Region 1 anchor will sponsor meetings and conferences to facilitate the opportunity for healthcare providers throughout the region and the state to share experiences, challenges, lessons learned and best practices. The leadership team for this project will actively participate in those opportunities.

Project Valuation: This project addresses a significant priority regional need (CN.1, CN.4, and CN.5) as a big problem; it requires an investment of dental practice site, dental health providers, health educators, equipment, and practice infrastructure to adequately demonstrate effectiveness of transforming the healthcare delivery system. As a result of these actions the health system should

[46] PEW Children's Dental Campaign, The PEW Center on The States, February 2012. *www.pewcenteronthestates.org/dental)*

experience: reduction of inappropriate use of the ED for dental health care, improved dental health outcomes via preventive and remedial services to the at risk population, and reduce expense for dental health care.

127278302.1.12 Pass 3b (127278302.1.6)	***1.8.6***	***N/A***	***THE EXPANSION OF EXISTING DENTAL CLINICS, THE ESTABLISHMENT OF ADDITIONAL DENTAL CLINICS, OR THE EXPANSION OF DENTAL CLINIC HOURS***	
		UPA		127278302
Related Category 3 Outcome Measure(s):	*3.IT-7.10*	127278302.3.37 Pass 3b (127278302.3.8)	*Decrease the percentage emergency department visits for dental care*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*RHP PP Milestone* – P-4 Establish additional/expand existing/relocate dental care clinics or space Metric 1 Number of additional clinics, expanded space, or existing available space used to capacity Baseline/Goal: Establish clinic ~~and establish baseline~~ Data Source: New dental care schedule or other document, completed exams, treatment plans **Milestone 1** Estimated Incentive Payment *(maximum amount):* $1,401,550		**Milestone 2** [I-14] Increase number of special population members that access dental services Metric 1 [I-14.1]: Increasing the number of children, special needs patients, pregnant women, and/or the elderly accessing dental services Baseline/Goal: Establish a baseline of TBD Data Source: Billing, consent forms, other documentation of dental services **Milestone 2** Estimated Incentive Payment: $1,193.374	**Milestone 3** [I-14] Increase number of special population members that access dental services Metric 1 [I-14.1]: Increasing the number of children, special needs patients, pregnant women, and/or the elderly accessing dental services Baseline/Goal: Baseline established in DY3/10% growth in volume as compared to baseline Data Source: Billing, consent forms, other documentation of dental services **Milestone 3** Estimated Incentive Payment: $1,114,002	**Milestone 4** [I-14] Increase number of special population members that access dental services Metric 1 [I-14.1]: Increasing the number of children, special needs patients, pregnant women, and/or the elderly accessing dental services Baseline/Goal: Baseline established in DY3/20% growth in volume as compared to baseline Data Source: Billing, consent forms, other documentation of dental services **Milestone 4** Estimated Incentive Payment: $949,054
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,401,550		Year 3 Estimated Milestone Bundle Amount: $1,193,374	Year 4 Estimated Milestone Bundle Amount: $1,114,002	Year 5 Estimated Milestone Bundle Amount: $949,054
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $4,657,980				

Project Option: 1.13.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization.
Unique Project Identification: 127278302.1.13 Pass 3b (127278302.1.7)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: This project is a collaboration of University Physician Associates with the executing provider Palestine Regional Medical Center, a 156 bed hospital that serves a population of 100,000 including Palestine/Anderson County and surrounding communities (approximately 1,000 square miles). A full range of comprehensive care is offered including the latest in diagnostic, therapeutic and rehabilitative services on both an inpatient and outpatient basis. Healthcare services include Acute Care, Behavioral Health Services (37 inpatient beds), Cardiac Care, Diagnostic Imaging, Emergency Services, Intensive Care, Interventional Cardiology, Obstetrics and Gynecology, Rehabilitation, Sleep Medicine, Surgery and Wound Care.

Intervention(s): The crisis stabilization unit will provide short term (24 to 72 hour) treatment for behavioral health patients requiring observation and stabilization from acute symptoms of mental illness thus reducing congestion in area emergency departments, decreasing admissions to medical acute care setting and ICU) while providing quicker treatment options for the behavioral health patient in the appropriate care setting.
Need for the Project: Currently with our closest neighboring counties (Anderson, Cherokee, Freestone, Henderson, Houston, Trinity and others) there are no crisis stabilization services/beds available. Therefore, when a mental health patient is in crisis and stabilization is required, one of several things happens: 1) admission to inpatient psychiatric services; 2) admission in the hospital system (typically ICU services); 3) patient waits in ER setting until discharge is appropriate; or 4) patient leaves without treatment against medical advice. All of these situations drain resources, result in excessive costs and do not benefit the patients in their time of crisis.
Target Population: The target population is the adult behavioral health patient in crisis due to mental health issues that require monitoring and/or psychiatric stabilization. In CY 2012 PRMC Inpatient Behavioral Health Services admitted 621 patients of those patients, over 53% of were referred from emergency departments (both PRMC and other hospitals within the Region) and over 43% of those patients are Medicaid eligible or indigent. The anticipated Medicaid/indigent benefit of a crisis stabilization unit is to provide those patients an alternative treatment option to the stress of emergency departments and/or inpatient psychiatric services.
Category 1 Expected Patient Benefits: I-12 Based on the projected staffing model to be used during the demonstration period, we anticipate an approximate monthly admission rate of 20 additional patients to the crisis stabilization unit beginning in DY2/3. This project seeks to increase the utilization of appropriate crisis alternatives by 5% in DY4 and by 10% in DY5.
Category 3 Outcomes: As a demonstration project, our goal is to reduce emergency room visits for behavioral health patients. Based on our recent emergency department activity with behavioral health inpatient admissions, we expect to reduce ER visits for behavioral health

patients by 240 patient visits in DY3 with addition decrease by 5% in DY4 and 10% in DY5 compared with DY3 baseline.

Project Narrative

Project Description: Palestine Regional Medical Center's (PRMC) proposal is to develop a crisis stabilization system that better identifies people with behavioral health needs, responds to those needs and links persons with the most appropriate level of care. Our goal is to keep individuals healthy and safe, develop processes and intervention to manage challenging behaviors, and avoid unnecessary use of emergency departments, hospitalization or incarceration.

The crisis stabilization unit is a short-term treatment model of 10 beds to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment. The program is designed to serve voluntary adult patients who can be stabilized within a 24 - 72 hour length of stay and who can then be linked to community supports.

A complete review of potential crisis alternative service models will be explored to determine acceptable and feasible models for implantation of this program.

Goal(s) and relationship to Regional goal(s):

Project goals: Promote better health outcomes for behavioral health patients. Decrease unnecessary ED visits. Decrease unnecessary admissions and readmissions.

This project addresses the RHP Region 1 goals of improving access to the right care at the right time and thereby improving patient satisfaction while reducing the cost burden on the health care system. Improved access to care and patient satisfaction will be achieved more economically by addressing shortages in behavioral health, which is a key health challenge in the community needs assessment for Region 1. Furthermore, this project will prevent unnecessary hospitalizations, which is also a key challenge reported in the community needs assessment.

Challenges:

The challenges of the current system available in this region are an increased load in area emergency department, excessive use of ICU or acute care services to treat behavioral health patients requiring crisis intervention, inadequate treatment options for patients in crisis that don't need full inpatient services and draining local law enforcement agencies and judicial systems with behavioral health patients ending up in the judicial system rather than appropriate treatment programs. The primary challenge to rapid implementation of this infrastructure project will be guiding the referral sources identified above, to utilize the assessment protocol to determine the appropriate setting for the patient in question. This challenge will be addressed through implementation of project 127278302.1.10 Pass 3b (127278302.1.3) and related training (both in-person and virtual) that will place high quality audio and video equipment for jails and criminal justice access in order to facilitate dispensation of behavioral health patients to the appropriate care setting.

5-year expected outcome for provider and patients:

With the addition of crisis stabilization services to the current programs offered at PRMC the goals are to decrease emergency department visits by behavioral health patients thus increasing bed availability for acute patients; decrease emergency department wait times which currently average 8-10 hours causing emergency department bottlenecks; decrease unnecessary admissions to inpatient behavioral health programs and or county jails/judicial systems. All of these situations will result in a significant cost savings for area hospitals, LMHA and county justice organizations. And behavioral health patients will receive necessary treatment in a more efficient and timely manner.

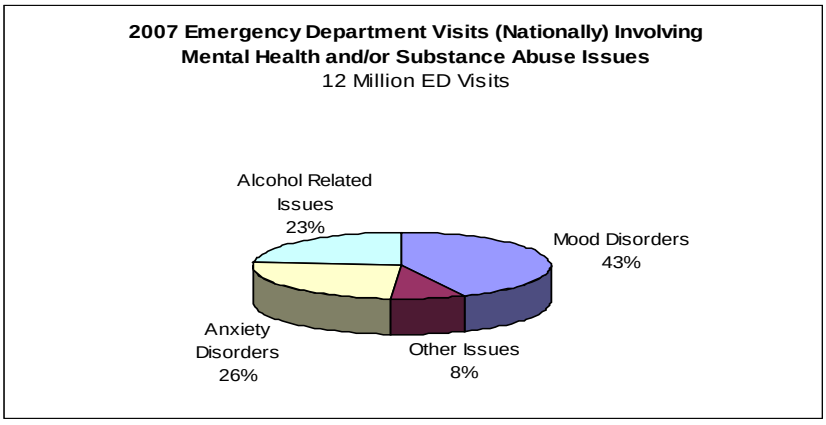
The anticipated Medicaid/indigent benefit of a crisis stabilization unit is to provide those patients an alternative treatment option to the stress of emergency departments and/or inpatient psychiatric services. Based on the projected staffing model to be used during the demonstration period, we anticipate an approximate monthly admission rate of 20 additional patients to the crisis stabilization unit beginning in DY2/3. This project seeks to increase the utilization of appropriate crisis alternatives by 5% in DY4 and by 10% in DY5.

Starting Point/Baseline:

PRMC does not have a crisis stabilization center. Therefore, the baseline data for all metrics will be set to 0. Time period for baseline: 6/30/12

Rationale:

According to a News and Numbers report from the Agency for Healthcare Research and Quality (AHRQ), nearly 12 million visits made to U.S. hospital emergency departments in 2007 involved people with a mental disorder, substance abuse problem or both. This accounts for 1 in 8 of the 95 million visits to EDs by adults that year.[1]



PRMC 2011 statistics show 649 behavioral health patients were seen in the emergency department with 170 of these patients transferring into the ICU – 48% of ICU patients were for behavioral health issues and 12% were from drug/alcohol related issues. ACCESS (LMHA for Anderson and Cherokee counties) responded to 1,198 behavioral health crisis contacts in that year. After consulting with PRMC emergency and ICU departments, ACCESS, area county

judges, area county sheriff departments, it was determined that crisis stabilization services would be a beneficial addition to the current behavioral health services offered.

Currently in our local region (Anderson, Cherokee, Freestone, Henderson, Houston, Trinity and other surrounding counties) there are no crisis stabilization services/beds available. Therefore, when a mental health patient is in crisis and stabilization is required, one of several things happens: 1) admission to inpatient psychiatric services; 2) admission in the hospital system (typically ICU services); 3) patient waits in ER setting until discharge is appropriate; or 4) patient leaves without treatment against medical advice due to frustration. All of these

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[1] AHRQ News and Numbers is based on data in Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007

situations drain resources, result in excessive costs and do not benefit the patients in their time of crisis.

PRMC has a 37 bed inpatient psychiatric unit - 19 bed geriatric unit (55 yrs and older) and 18 bed adult unit (18-54 years old). Over 523 patients have been admitted to the adult inpatient unit with 13.9% of patients remaining in treatment less than 3 days. The primary reason for this statistic is that these patients only required crisis stabilization and local mental health authorities only fund 3 days to stabilize patients. PRMC has one board certified psychiatrist and one dual certified psychiatric neurologist. Having a psychiatric neurologist on staff will allow comprehensive treatments that will examine and address the physical and psychological components of a crisis patient's illness, thus getting them to appropriate treatment programs (physical or psychological) more quickly. (Psychiatric neurologists practice the subspecialty of psychiatry with a focus on the brain-behavioral connection.)

The Department of State Health Services estimates that over 85,000 individuals in the region have a serious mental illness, with well over 100,000 needing treatment for alcohol/drug use.[2] According to ACCESS (LMHA for Anderson and Cherokee counties) they have responded to 1,198 crisis contacts in one year – less than 1% of these patients were admitted into inpatient behavioral health service at PRMC.

Region 1 covers almost 20,000 square miles and has a population of 1,357,189 people.[3] Over 22% of this population resides in the southern counties of Anderson, Cherokee, Henderson, Houston, Freestone, and Trinity, covering over 6,700 square miles. PRMC currently serves these counties for medical and behavioral health needs. There are no crisis stabilization services/beds available in these counties and less than 200 behavioral health inpatient beds available (PRMC with 37 beds and Rusk State Hospital with approximately 172 beds – varies depending on forensic and residential requirements).

Project components:

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients.

d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.

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[2] Department of State Health Service

[3] US Census Bureau 2010 population data

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

Milestones & Metrics:

The milestone and metrics selected were chosen to establish a system to best deliver crisis stabilization services to a currently underserved population ultimately reducing costs for area hospitals and EDs, judicial systems, etc. Process milestones for DY2 include P-1 – conduct stakeholder meetings and P-4 hire and train staff to implement identified crisis stabilization services. This preparatory work is essential to assure that referral protocols are understood and that the unit is prepared to receive patients and delivery excellent care. The selected process milestones in DY 3 is P-5: develop administration of operational protocols and clinical guidelines for crisis service and P-7: participate in at least quarterly interactions with other providers to promote collaborative learning around shared or similar projects. RHP Region 1 has significant behavioral health services needs. Achievement of these process milestones will help the entire region respond to the service needs. The improvement milestone selected to demonstrate the intended success of this program is I-12: utilization of appropriate crisis alternatives. These milestones will ensure achievement of DSRIP goals of continuous quality improvement and collaborative learning in effort to achieve higher level of performance and outcomes within the 5 years of the program.

Unique community need identification number the project addresses:

CN.1 – Insufficient access to primary and specialty health care services.

CN.2 – Insufficient access to mental and behavioral health services.

CN.3 – High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.

CN.5 – Inappropriate emergency department utilization.

This project will significantly enhance the existing delivery system by providing much needed access to a facility for appropriate, cost-effective management of patients experiencing acute behavioral health episodes. Palestine Regional Medical Center statistics show 170 behavioral health patients in 2011 spent days in the ICU for a total cost of $700,000 annually and an additional $450,000 ER visits and waiting times. If crisis stabilization services had been available, significant costs savings would have resulted. Crisis stabilization services within the southern area of this region would significantly and positively impact the entire region by expanding services offered to an underserved population.

PRMC owns a 100,000 square foot facility that currently is only being used at a 33% capacity including the operating behavioral health inpatient services for both adult and geriatric inpatient programs and geriatric intensive outpatient program. This facility already has the infrastructure available to add a secure 10 bed crisis stabilization unit with minor modifications and upgrades. In addition to the crisis stabilization unit, support services will include a Behavioral Health Assessment Team (BHAT), crisis hotline number and dispatch services for assessments, consultations and transportation services. Current staffing protocols used for the inpatient programs would be applied to the crisis stabilization unit.

Development of appropriate outpatient services will be collaboration with Anderson Cherokee Counties Enrichment Services (ACCESS), our local mental health authority, in order to enhance both existing and new services.

Related Category 3 Outcome Measure(s): IT-9.2 Appropriate ED Utilization

Emergency Department data relating to selected Category 3 outcomes are described above and is identified as a community need by the RHP. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 47.6% of adults with serious mental illness in the past year used emergency departments as opposed to only 30.5% of those without past-year serious mental illness.[4] The crisis stabilization unit will allow behavioral health patients that are medically stable (no acute care issues) to bypass the emergency department and/or admission to acute care settings (e.g. Intensive Care Units) and be placed in a secure/safe environment for evaluation for appropriate treatment.

Relationship to Other Projects: This project will lay a foundation for, and reinforce the clinical effectiveness of, other DSRIP projects such as:

1.3 Implement Technology Assisted Services for Behavioral Health Care
1.10 Enhance Performance Improvement and Reporting Capacity
2.2 Expand Chronic Care Management Models
2.4 Redesign to Improve Patient Experience
2.5 Redesign for Cost Containment

Relationship to Other Performing Providers' Projects in the RHP:

Telemedicine services program (DSRIP 127278302.1.10 Pass 3b (127278302.1.3)) being proposed by University Physicians Associates will work hand-in-hand with the crisis stabilization services and intensive outpatient services to improve delivery of behavioral health services to area patients.

Plan for Learning Collaborative:

Palestine Regional Medical Center plans to collaborate with UT Health Science Center Tyler and other providers within the region with similar crisis intervention projects.

Participation in learning collaborative efforts will encourage alliances across the region by allowing providers to share lessons learned, challenges faced and develop best practices that will ultimately benefit recipients of the services provided.

Project Valuation:

In valuing this project, PRMC took into account the extent to which the implementation of a crisis stabilization center would provide cost avoidance with reduced emergency department costs by placing behavioral health crisis patients into a safe environment outside the ED while awaiting appropriate treatment options. This placement of patients outside of the

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[4] *Physical Health Conditions among Adults with Mental Illnesses* report based on Substance Abuse and Mental Health Services Administration (SAMHSA) 2008-2009 National Survey on Drug Use and Health (NSDUH) data

ED will allow for increased bed availability for acute care patients requiring right care at the right time thus increasing revenue potential. In addition to excessive ED costs, patients also incur costs for being admitted to inpatient facilities and/or jail. Providing patients the option of crisis stabilization will reduce premature placement into inpatient services and save county judicial and law enforcement organizations costs by reducing unnecessary oversight in ED requirements and/or incarceration.

127278302.1.13 PASS 3B (127278302.1.7)	**1.13.1**	**1.13.1 A-E**	**DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS AN ALTERNATIVE TO HOSPITALIZATION**
UPA			127278302
Related Category 3 Outcome Measure(s):	127278302.3.38 Pass 3b (127278302.3.9)	IT-9.2	Appropriate ED Utilization

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff, and social workers from EDs and psychiatric hospitals, EMS and relevant community behavioral health service providers Metric 1 P-1-1 Baseline/Goal: Number of meetings Data Source: Attendance lists Milestone 1 Estimated Incentive Payment (Max amount)*:* ~~**$346,559.17**~~ **$357,212** **Milestone 2 P-4: Hire and train staff to implement identified crisis stabilization services.** Metric 4 P-4-1 Baseline/Goal: Number of staff hired and trained a. Staff rosters and training records b. Data source: Training curricula	**Milestone 3 P-5: Develop administration of operational protocols and clinical guidelines for crisis services** Metric 5 P-5-1 Baseline/Goal: Completion of policies and procedures a. Data source: Internal policy and procedures documents and operations manual. Milestone 3 Estimated Incentive Payment (Max amount): ~~**$378,077.33**~~ **$388,829.50** **Milestone 4 P-7: Participate in at least quarterly interactions (meetings, conference call or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects** Metric 7 P-7-1 Baseline/Goal: Number of quarterly meetings, conference calls or webinars organized by the RHP	**Milestone 5 I-12: Utilization of appropriate crisis alternatives.** Metric 1 I-11.1: Goal: **5%** increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. c. Data source: Claims, encounter and clinical record data. d. Rationale: see project goals. Milestone 5 Estimated Incentive Payment (Max amount): **$758,353**	**Milestone 6 I-12: Utilization of appropriate crisis alternatives.** Metric 1 I-11.1: Goal: **10%** increase in utilization of appropriate crisis alternatives. e. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives f. Denominator: Number of people receiving community behavioral health services in RHP project sites. g. Data source: Claims, encounter and clinical record data. h. Rationale: see project goals. Milestone 6 Estimated Incentive Payment (Max amount): **$626,465**

127278302.1.13 PASS 3B (127278302.1.7)	**1.13.1**	**1.13.1 A-E**	**DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS AN ALTERNATIVE TO HOSPITALIZATION**	
UPA				127278302
Related Category 3 Outcome Measure(s):	127278302.3.38 Pass 3b (127278302.3.9)	IT-9.2	Appropriate ED Utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment (Max amount): ~~$346,559.17~~ **$357,212**	that the provider participated in. a. Data source: Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. Metric P-7-2 Baseline/Goal: Share challenges and solutions successfully during quarterly interaction. a. Data source: Catalog of challenges, solutions, tests and progress shared by participating provider during quarterly interaction. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. Milestone 4 Estimated Incentive Payment (Max amount): ~~$378,077.33~~ **$388,829.50**			
Year 2 Estimated Milestone Bundle Amount: $714,424	**Year 3 Estimated Milestone Bundle Amount: $777,659**		**Year 4 Estimated Milestone Bundle Amount: $758,353**	**Year 5 Estimated Milestone Bundle Amount: $626,465**

127278302.1.13 PASS 3B (127278302.1.7)	**1.13.1**	**1.13.1 A-E**	**DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS AN ALTERNATIVE TO HOSPITALIZATION**
UPA			127278302
Related Category 3 Outcome Measure(s):	127278302.3.38 Pass 3b (127278302.3.9)	IT-9.2	Appropriate ED Utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,876,901

Project Option: 1.1.1 Expand Primary Care Capacity – Establish more primary care clinics
Unique Project Identifier Number: 127278302.1.8 (Pass 2)
Performing Provider Name/TPI: UTHSCT– MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. The University of Texas Health Science Center at Tyler (UTHSCT) with its University Physician Associates (UPA) faculty, is the only academic health science center in the region. The UTHSCT is comprised of a 109 bed acute care hospital, a state of the art cancer treatment center, primary and specialty care services and three remote satellite clinics to improve access to care for this largely rural area.
Intervention: This new infrastructure project will increase access to a poor, largely minority, underserved area of Smith County (75702) by establishing an open access clinic within the community to provide basic care services and a referral channel to patient centered medical homes and specialty providers.
Need for the Project: There is no other operating hospital facility on the north side of the community; access to primary as well as specialty care medical services is limited for this population which also has a high concentration of African-American and Hispanic residents. On average residents of this zip code make 967 UTHSCT ED visits; 85% are considered non-emergent encounters. 52% occurred after normal business hours and 35% during weekends.
Target Population: The population of zip code 75702 is 49 percent African American and 34.5 percent Hispanic/Latino (2000 US Census). Nineteen (19) percent are under the age of 9, and 13 percent over the age of 60. Nearly 50 percent of households have an income of less than $25,000 annually with 4.8 percent unemployed, 28 percent are considered below poverty level, and over 25 percent are without any form of health care insurance coverage.
Category 2 Expected Patient Benefits: The project intends to provide basic care and referrals in DY 4 by an increase of 3% over the baseline established in DY3 and by an increase of 5% in DY5 over the DY3 baseline. This project is expected to target a base patient/client population of 26,259, providing unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, it is estimated that up to 2,000 patients/clients will receive or be engaged in primary care clinic access services by DY5, who did not previously have direct access to such services. The improvement milestone selected for this project to increase access to primary care capacity and to increase the volume or primary care clinic visits directly reflects the quantitative impact of the project on the population served.
Category 3 Outcomes: IT-11.1 our goal is to improve minority and health disparity populations' outcomes on a clinical indicator (~~TBD considering DY3 baseline data~~ number of assessments performed for African American men over the age of 45 evaluating an increased risk for prostate cancer with documented physician communication about decision to be tested for prostate cancer) by X% (TBD) in DY4 compared to the baseline established in DY3 and by X% TBD in DY5 compared to the DY3 baseline. IT- 12.5, USPSTF-endorsed screening outcome measure (screening for high blood pressure in adults over the age of 18 is selected to identify adults at an increased risk for cardiovascular disease due to high blood pressure) (USPSTF,

2013). ~~Baseline data collected on the individuals whom use the clinic in DY2-DY3 along with input from the community advisory group will determine the most relevant screening measure to use as an intervention target. The numerator and denominator will be derived from DY3 baseline data to establish the % improvement in DY4 and DY5 compared to the baseline.~~ The numerator will be the number of patients over the age of 18 who undergo blood pressure screening. The denominator will be the number of patients over the age of 18 receiving care at this new clinic. The goal will be to increase the number of patients screened by %TBD in DY 4 and DY 5 derived by the baseline data established in DY 3.

Project Narrative

Project Description: Rural communities differ in population density, remoteness from urban areas, and in other cultural, economic, and social characteristics. Generally, the smaller, poorer, and more isolated these communities, the less accessibility there is to high-quality health services. (AAMC, 2012) In 2001, the Institute of Medicine (IOM) published its landmark report *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report called for fundamental changes in a health care system with serious shortcomings. A series of *Quality Chasm* reports have since followed including one on The Future of Rural Health Care. (IOM, 2005) In it, the IOM crafted a multi-pronged strategy to address quality challenges in rural communities. Among these strategies was a recommendation to: "Enhance the human resource capacity of rural communities, including the education, training, and deployment of health care professionals, and the preparedness of rural residents to engage actively in improving their health and health care."

Access to an adequate supply of well-educated, culturally competent, and highly trained physicians in rural areas is essential to deliver quality health care. (AAMC, 2012) This statement becomes even more compelling as the Medicare age population continues to grow and as the Supreme Court upheld Affordable Care Act requires millions of Americans to become newly insured. Projections are that the United States will face a shortage of nearly 100,000 doctors by 2020, and underserved populations will continue to carry the heaviest burden of both a primary care workforce and specialist shortage. Texas, both urban and rural, has not been spared from this shortage of physicians and specialists.

Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. The University of Texas Health Science Center at Tyler (UTHSCT) with its University Physician Associates (UPA) faculty, is the only academic health science center in this region drawing its patient base from the population of nearly 1.5 million Texans who reside in this corner of the state. The region has higher numbers of uninsured residents with 54 percent of these Texans either uninsured or enrolled in some form of publicly funded insurance. The region is more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. Findings of this assessment revealed higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. (Texas DSHS, 2007)

UTHSCT is located in the northernmost section of the Tyler city limit. It serves a large rural population to the north of Tyler, but also provides health services to the poorer and more vulnerable communities which disproportionately reside on Tyler's north side. There is no other operating hospital facility on the north side of the community and access to primary as well as specialty care medical services is limited in this population which also has a higher concentration of African-American and Hispanic residents.

The **goal** of this DSRIP project is to create the necessary infrastructure to provide sustainable open access to basic care services and the availability of referral channels to patient centered medical homes within UTHSCT/UPA as well as targeted specialty providers. Future collaborative opportunities with partners in the region will also provide for increased access to behavioral health care. Specifically, this project proposes to organize, staff, and operate a clinic facility in the 75702 zip code located directly within the North Tyler community which will make this level of basic medical care more readily available to them.

Challenges to accomplishing this goal will include critical barriers to the recruitment and retention of physician care providers for an open access facility of this nature as well as qualified personnel resources. Creating awareness and trust to precipitate change within the local community of this zip code in order to transform health care utilization is likely to be met with some resistance. However, UTHSCT's recognized outreach efforts in Tyler, its reputation for providing rapid service with high satisfaction, and its relatively close proximity to what will be a new satellite clinic, will help to reduce these anticipated barriers. The project will also address these challenges early by conducting focus groups within the target region, engaging the faith-based community, and deploying community health workers to further enhance outreach initiatives. UTHSCT/UPA will be able to extend its electronic health record to this open access clinic to facilitate the referral process and to secure future medical homes for these individuals in order to increase primary care and preventive care delivery which will reduce utilization of costly services. Healthcare team professionals will be trained on processes, guidelines, and technology which will optimize timely referrals as appropriate.

This project is designed to make a significant impact on the following regional goals: 1) Improve access to health care services by increasing service availability and clinic locations, 2) improve the quality of care and patient satisfaction by optimizing timely referrals to and consultations with selected medical specialties, and 3) reduce the cost of health care by improving early diagnosis and management of disease processes.

Implementation metrics will include process/intervention milestones directed at project planning, recruiting primary care providers and staff, operationalizing the new clinic, training personnel, expanding non-traditional hours of operation, increasing reach to the target community, and increasing the number of visits to this new facility beyond the baseline established by the end of DY3. Intervention targets will include selection and enhancement of an evidence-based screening measure as well as reduction of emergency department utilization. The **expected outcome** by the conclusion of the project in DY5 will be to develop/implement a sustainable open access plan which will meet the gap in service available to the patient population of zip code 75702. This will also result in performance achievement of Category 3 intervention targets supportive of improved patient experience in keeping with regional goals.

Starting Point/Baseline: The population of zip code 75702 is 49 percent African American and 34.5 percent Hispanic/Latino (Demographic data for 75702, 2000 US Census). Nineteen (19) percent are under the age of 9, and 13 percent over the age of 60. Over 40 percent of the adults have not graduated from high school. Nearly 50 percent of households have an income of less than $25,000 annually with 4.8 percent unemployed, 28 percent considered below poverty level, and over 25 percent without any form of health care insurance coverage. It is anticipated that more current demographic data by zip code will come available soon from the 2010 US Census.

During the period from September 1, 2010 through August 31, 2012, zip code 75702 generated 1,953 Emergency Department visits to UTHSCT, or 976 visits per year, averaging 2.67 visits per day. Overall, roughly 85 percent of visits to this Emergency Department in the same time frame are considered to have been non-emergent encounters, neither requiring admission or observation. Further, 52 percent of these visits occurred after usual business hours (4 p.m. to 8 a.m.) and 35 percent during weekends. Of course, these data do not reflect the experience of other emergency departments in the region which may service 75702. It is anticipated that this zip code will be the primary patient source of clients to be served by this new clinic which will create access to primary care which can reduce unnecessary emergency department visits and costs.

There is no additional baseline information currently available. As DY2 and DY3 of this project will largely be focused on recruiting primary care providers and staff, operationalizing the new clinic, training personnel, and expanding non-traditional hours of operation, the proposed time period to be used as a baseline of clients served will be from calendar year 2014.

Rationale: Expansion of primary care services through the establishment of a basic health care clinic in a community experiencing health disparities is a justified and imperative response based on evidence that indicates "1) health is better in areas with more primary care physicians, 2) people who receive care from primary care physicians are healthier, and 3) the characteristics of primary care are associated with better health." (Starfield, 2005)

The rationale for this proposal harmonizes with the RHP Planning Protocol for DSRIP project option 1.1 to expand primary care capacity. Based on the health indicators and service needs of the target population described above, the location of a clinic in an underserved community will improve access to care by minimizing transportation challenges as a result of the clinic location. Creation of basic health care clinic will provide timely access to a health care provider. Since the clinic will serve as a medical home for area residents, care and follow-up will be more easily coordinated thus reducing inappropriate utilization of more costly emergency room use. This community-based facility will benefit from periodic community advisory meetings thereby establishing a partnership with community opinion leaders that will promote appropriate use of the health care system.

This project specifically addresses several identified Community Needs including: CN.1 - insufficient access to primary and specialty health care. Additionally, it responds to CN.3- high rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer. Evidence also indicates that access to timely primary care reduces high costs due to potentially preventable hospitalizations; Region 1 has identified a need - CN.4 to reduce potentially preventable hospitalizations which is also linked to CN.5 inappropriate emergency department utilization.

Given the absence of access to primary care for residents of this community, the proposed new primary care clinic will improve health outcomes through a series of steps as follows:
Establish the facility and service infrastructure to deliver timely basic health care for an underserved population who experience health disparities
Train/educate project team professionals on processes to assure coordination of services, referral and follow-up procedures (including behavioral health services), patient self-management coaching, implementation of quality metrics, and utilization of integrated health information with electronic medical records
Implement coordinated referrals for whole person care by engaging with partners to provide services for behavioral health needs
Support coordination of care to include facilitation of 1) obtaining medications, 2) additional lab work, 3) preventive screening services, 4) home health services, 5) and referral for more advanced care as necessary
Conduct quality improvement activities to identify barriers to timely referral consultations, and assess effectiveness of complete communication to assure coordination of care where possible. Plan-Do-Study-Act (PDSA) or similar methodology will be applied.
Related Category 3 Outcome Measure(s): Two Intervention targets from separate Outcome Domains have been selected to validate the effectiveness of implementing this project to improve access to care for a well-defined population that exhibit health disparities. From the Category 3 Outcome DomainOD-11 Intervention Target 11.1 – Improvement in clinical indicator in identified disparity group will be used to measure the success of the project. ~~A baseline review of diagnostic codes for residents from the 75702 zip code who use the newly established clinic will be used to determine the clinical indicator to establish a baseline for the clinical indicator to be improved for targets for DY4 and DY5.~~ The goal will be to increase the number of assessments performed for African American men over the age of 45 evaluating an increased risk for prostate cancer with documented physician communication about decision to be tested for prostate cancer. Baseline data will be established for this new clinic in DY 3 and will be used to derive the improvement target goals for DY4 and DY 5.
Outcome Domain 12 – Primary Care and Primary Prevention provides the second Intervention Target; *IT-12.5 USPSTF-endorsed screening outcome measures* has been selected as an improvement milestone for this project. ~~Baseline data collected on the individuals whom use the clinic in DY2-DY3 along with input from the community advisory group, will help guide the determination of the most appropriate screening measure to use as a~~ Screening for high blood pressure in adults over the age of 18 has been chosen as an improvement milestone for this project as a barometer for health improvement of the target population as a result of better access to care, better coordination of care, referral and follow-up for advanced care as needed, and improved health knowledge/behaviors. Baseline data will be established for this new clinic in DY 3 and will be used to derive the improvement target goals for DY 4 and DY 5.
Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure, clinical and educational expertise to benefit the following RHP projects.
127278302.1.4 – Increase Training of Primary Care Workforce; Capacity Building through Workforce Development: Training Community Health Workers (CHWs)
127278302.2.1 – Enhance/Expand Medical Homes for UPA Primary Care Clinics

127278302.2.5 – Evidence-based Disease Prevention: Expand Delivery of Early Colon Cancer Treatment and Secondary Prevention Management
127278302.2.18 Pass 3b (127278302.2.7) – Integrate Primary and Behavioral Health Care Services
This project could also have implications for Category 4 measures such as patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.
Relationship to Other Performing Providers' Projects in the RHP: Providers will participate in the learning collaborative through The Northeast Texas Center for Rural Community Health (see below).
Plan for Learning Collaborative: The Northeast Texas Center for Rural Community Health (The Center) is housed at the University of Texas Health Science Center at Tyler. It was established to 1) facilitate community health service and education activities within the Northeast Texas region, 2) enhance the promotion, coordination, and support broad-based faculty and student projects intended to improve the health care delivery system and improve the quality of care delivered.

The Center will convene internal and external stakeholders who will assist with the identification of community needs, support implementation of projects and activities to improve population health, participate in the planning and delivery of educational programs for professionals and the public, provide a platform for sharing successes and challenges with health delivery systems implementation, lend scholarly and academic assistance to the design of projects and reporting of results/findings and best practices with particular attention to care for rural populations.
Project Valuation: Rural populations continue to carry the heaviest burden of the consequences of health care gaps in both a primary care workforce and access to even basic health care services. Infrastructure and capacity building investment in this project is intended to increase access points to primary care by expanding the number of the UTHSCT/UPA clinics and specifically targets service delivery for the patient population residing in zip code 75702. This geographic area is home to a significant proportion of minority residents living in poverty who have not had the benefit of personal health knowledge to the same extent as others who have had greater access to preventive health information, personal health care knowledge, and the opportunity to proactively seek routine versus acute care. In addition, minority populations may face additional access barriers as a result of language/communication limitations, cultural beliefs, and lack of understanding of how to navigate the complex health care system.
Evidence suggests that areas with higher ratios of primary care physicians to population experience lower health care costs than other areas, this may be a function of better preventive care and lower hospitalization rates. (Starfield 2005) Despite recognized challenges to providing primary care which include managing co-morbidities, coordinating care through referral and follow-up with results to the primary care provider, and patient education to reinforce adherence to a care plan, establishing a clinic in an easily accessed location for this community will increase the value of the project beyond the monetary cost savings.
The value of this project was determined based on consideration of responsiveness to community needs, cost-savings realized by increasing access to primary care for an un-served,

population thereby decreasing inappropriate use of emergency departments, and improved preventive health care behaviors.

Input from a community advisory group will engender support for use of the basic health care clinic by area residents to reduce health disparities, establish a mechanism for health promotion, and foster community participation to support healthy behaviors. Enhanced access to services, with community support is likely to enhance patients' ability to access the right care at the right time in the right setting. This will not only enhance patient satisfaction with the health care system, it will facilitate health behavior changes the mediate and prevent exacerbation of morbidity and premature mortality.

By the end of DY3, the project will have sufficient baseline data against which to measure ED use by 75702 residents and also to establish a substantial evidence-based outcome measures which respond to the health/disease profile of the community. The data will guide the project team to focus on addressing patients with priority conditions in order to reduce the financial burden to the regional health care system through early detection and management of disease thereby reducing morbidity and utilization of high costs services, e.g. emergency room use.

References:

Association of American Medical Colleges (AAMC). AAMC physician workforce policy recommendations, September 2012. Available at: https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendations.pdf (last accessed 10-06-2012).

Institute of Medicine. Quality through collaboration: the future of rural health. Washington, D.C.: The National Academies Press, 2005, 288 pp. Available at http://www.nap.edu/catalog/11140.html (last accessed 10-01-2012).

Starfield B, Shi L, Mancinko J; (2005) Contribution of primary care to health systems and health. The Milbank Quarterly, vol. 83(3): 457-502.

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10-04-2012).

U.S. Preventive Services Task Force (USPSTF). USPSTF A and B recommendations, 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last accesssed 02-25-2013).

127278302.1.8	1.1.1	1.1.1	Establish More Primary Care Clinics	
		University Physician Associates		*127278302*
Related Category 3 Outcome Measure(s):	**127278302.3.28** **127278302.3.29**	**3.IT-11.1** **3.IT -12.5**	**Improvement in Clinical Indicator in Identified Disparity Group – Assessment of prostate cancer risk** **Other USPSTF-endorsed screening outcome measures – screening for high blood pressure in adults**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**YEAR 4 (10/1/2012 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1 Establish additional/expand existing, relocate primary care clinics Metric 1 Number of additional clinics or expanded hours or space*:* Baseline/Goal: Documentation of detailed expansion plans Data Source: New primary care schedule Milestone 1 Estimated Incentive Payment $2,042,922	**Milestone 2** *P-5*: Train/hire additional primary care providers and staff Metric 1 *P-5.1 Documentation of increased number of providers and staff and/or clinic sites*: Baseline/Goal: Documentation of completion of all required items per RHP Data Source: Performing Provider report, contracts & HR documentation Milestone 2 Estimated Incentive Payment: $1,156,718 **Milestone 3** *P-4*: Expand hours of primary care clinic, including evening and/or weekend hours Metric 1 *P-4.1*: Increase the # of clinic hours over baseline Baseline/Goal: one weekend day/week and increase of 10 hrs/week Data Source: Clinic documentation Milestone 3 Estimated Incentive Payment: $1,156,718		**Milestone 4:** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 *I-12.1:* Documentation of increased number of visits improved over prior reporting period. Goal: Increase in total number of visits for reporting period; 3% over baseline. Data Source: Registry, EHR, and Claims Milestone 4**:** Estimated Incentive Payment: $ 1,264,513 **Milestone 5***: I-15:* Increase access to primary care capacity. Metric 1 *1-15.*Increase percentage of target population reached. Goal: Increase the number of individuals of the target population reached compared to	**Milestone 6:** I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 *I-12.1:* Documentation of increased number of visits improved over prior reporting period. Goal: Increase in total number of visits for reporting period; 5% over baseline. Data Source: Registry, EHR, and Claims Milestone 6**:** Estimated Incentive Payment: $ $ 1,231.929.50 **Milestone 7***: I-15:* Increase access to primary care capacity. Metric 1 *1-15.*Increase percentage of target population reached. Goal: Increase the number of individuals of the target population reached compared to

127278302.1.8	**1.1.1**	**1.1.1**	**Establish More Primary Care Clinics**	
University Physician Associates				*127278302*
Related Category 3 Outcome Measure(s):	**127278302.3.28** **127278302.3.29**	**3.IT-11.1** **3.IT -12.5**	**Improvement in Clinical Indicator in Identified Disparity Group – Assessment of prostate cancer risk** **Other USPSTF-endorsed screening outcome measures – screening for high blood pressure in adults**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**YEAR 4 (10/1/2012 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			the number of individuals in the target population by 3% over baseline. Data Source: Documentation of target population reached in zip code 75702 Milestone 5: Estimated Incentive Payment: $ 1,264,513	the number of individuals in the target population by 5% over baseline. Data Source: Documentation of target population reached in zip code 75702 Milestone 7 Estimated Incentive Payment: $ 1,231.929.50 Estimated base client population to be targeted over the duration of this project: 26,259 Estimated volume of services provided over the duration of this project: 2,000
Year 2 Estimated Milestone Bundle Amount: $2,042,922	Year 3 Estimated Milestone Bundle Amount: $2,313,436		Year 4 Estimated Milestone Bundle Amount: $2,529,026	Year 5 Estimated Milestone Bundle Amount: $2,463,859
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $9,349,243				

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 130612806.1.1 (PASS 1)
Performing Provider Name/TPI: ETMC Jacksonville 130612806

Project Abstract

Provider: East Texas Medical Center Jacksonville (ETMC) is a 74-bed, full-service hospital dedicated to serving the Cherokee County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Cherokee County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 242,000.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, recruiting an internist and two pediatricians, and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Southeastern Region (Cherokee, Gregg, Panola, and Rusk Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 3,510 new clinic patients with a Medicaid and indigent share of at least 30%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and recruiting an internist and two pediatricians. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include an internist and two pediatricians. , and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services and pediatrics. The ETMC Southeastern Region is currently underserved by 36 primary care physicians—including a shortage of 20 internist and 11 pediatricians.

Service Area Population 242,017							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7		29.5	71	68	(3)
Geriatric Medicine	0	0	2.6	2.6	6	4	(3)
Internal Medicine	28.8	17.6		23.2	56	36	(20)
Pediatrics	12.8	12.9		12.9	31	20	(11)
Primary Care Total					**165**	**128**	**(36)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 34,061 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC's ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care

expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends and recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours and clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (130612806.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (130612806.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (130612806.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

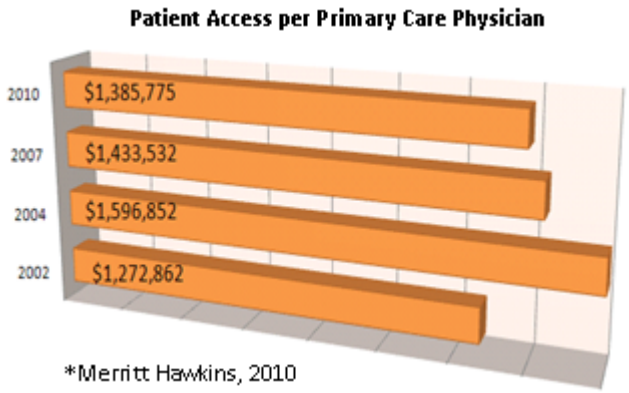
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $990,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $702,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		3,510
ED visits / year / person		0.45
Potential ED Visits		1,583
ED Visits Reduced @ 15%		237
Avg ED Payment		$425
ED Savings	**$**	**100,904**
IP Admissions / year / person		0.11
Potential IP Admissions		400
Admissions Reduced @ 18%		72
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**889,371**
Total Estimated Savings	**$**	**990,275**



130612806.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Jacksonville			*130612806*
Related Category 3 Outcome Measure(s):	***130612806.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline. **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment: $**552,710	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 5% over baseline of 34,061 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $602,977	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 10% over baseline of 34,061 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $604,729	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 15% over baseline of 34,061 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $499,559
Year 2 Estimated Total DSRIP: $552,710	Year 3 Estimated Total DSRIP: $602,977	Year 4 Estimated Total DSRIP: $604,729	Year 5 Estimated Total DSRIP: $499,559
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$2,259,975***			

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 130862905.1.1 (PASS 1)
Performing Provider Name/TPI: ETMC Clarksville 130862905

Project Abstract

Provider: East Texas Medical Center Clarksville (ETMC) is a 36-bed, full-service hospital dedicated to serving the Red River County area with advanced diagnostics, medical and surgical care, and outpatient services. ETMC's primary service area is Red River County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 120,272.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, recruiting two primary care providers and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Northern Region (Camp, Franklin, Red River, Wood, and Upshur Counties) that currently do not have sufficient access to primary care. We expect to serve approximately an average of 2,350 new clinic patients with a Medicaid and indigent share of at least 20%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 96% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and recruiting two primary care providers. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by a 96% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions

are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include two primary care providers and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services ~~and pediatrics~~. The ETMC Northern Region is currently underserved by 33 primary care physicians~~—including a shortage of 10 pediatricians~~.

Service Area Population 120,272							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7		29.5	35	33	(2)
Geriatric Medicine	0	0	2.6	2.6	3	1	(2)
Internal Medicine	28.8	17.6		23.2	28	10	(18)
Pediatrics	12.8	12.9		12.9	15	5	(10)
Primary Care Total					**82**	**49**	**(33)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current

physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 3,374 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC's ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends and recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours and clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (130862905.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (130862905.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (130862905.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

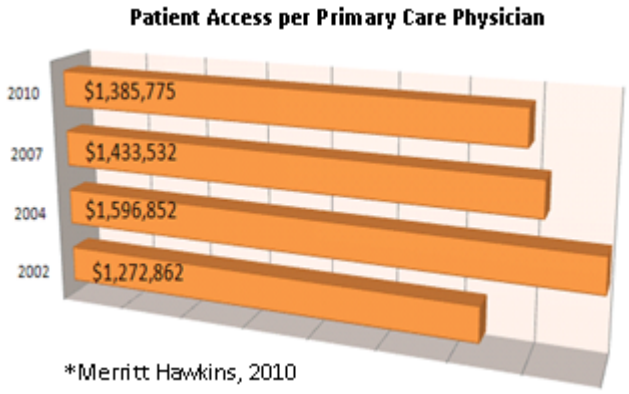
Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data

on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $700,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $631,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

The charts below show the annual estimated program savings and access expansion:

Estimated Savings Expand Primary Care Capacity		
Total New Clinic Patients		2,467
ED visits / year / person		0.45
Potential ED Visits		1,113
ED Visits Reduced @ 15%		167
Avg ED Payment		$425
ED Savings	**$**	**70,932**
IP Admissions / year / person		0.11
Potential IP Admissions		281
Admissions Reduced @ 18%		51
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**625,197**
Total Estimated Savings	**$**	**696,129**



130862905.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Clarksville			*130862905*
Related Category 3 Outcome Measure(s):	***130862905.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline. **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $496,848	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 58% [1,410] over baseline of 2,450 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $542,035	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 77% [1,880] over baseline of 2,450 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $543,610	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 96% [2,350] over baseline of 2,450 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $449,069
Year 2 Estimated Total DSRIP: $496,848	Year 3 Estimated Total DSRIP: $542,035	Year 4 Estimated Total DSRIP: $543,610	Year 5 Estimated Total DSRIP: $449,069
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$2,031,562***			

Project Option 1.1.2-Expand Existing Primary Care Capacity
Unique Project ID: 131037704.1.1 (Pass 1)
Preforming Provider Name/TPI: Hopkins County Memorial Hospital 131037704.

Project Abstract

Provider Description: Hopkins County Memorial Hospital (HCMH) is a 96 bed acute hospital located in Sulphur Springs with an estimated population of 18,000 and is the only hospital provider serving Hopkins County which has a population of approximately 30,000. Hopkins County Memorial Hospital currently employs primary care providers and has 13 physicians and 10 mid-levels.

Intervention(s): This project will expand primary care capacity by hiring two primary care providers to practice in our established Rural Health primary care clinic.

Need for the Project: We have lost four primary care providers in the last two years and according to our strategic plan and needs assessment, we were already 3-4 physicians short. We have more demand than supply of primary care providers.

Target Population: The target population is all the patients in our market area which is Hopkins County and adjacent counties who need access to primary care physicians with a special emphasis to our Medicaid population. As of 9/30/12, our payer mix was approximately 23% Medicaid and Self Pay patients so the expectation will be the same proportion of low income patients will benefit.

Category 1 or 2 Expended Patient Benefits: The project seeks to provide 4200 visits per provider by DY5.

Category 3 Outcomes: IT-6.1 Our goal is to improve timeliness of appointments and information that will be evident on the patient satisfaction survey.

Project Narrative

Project Description: The project involves the recruitment and employment of 2 primary care providers. Access to primary care is the foundation for providing timely preventative visits and coordination of proactive care. Difficulties in getting appointments and extended wait times have a negative impact on quality of care and coordination of care. This also leads to a decrease in patient satisfaction and may even discourage patients to access care. The ratio of patients to providers is significantly higher in our region than in statewide averages or national benchmarks. We have many small acute care hospitals in East Texas located in rural communities which lack sufficient primary care providers. Hopkins County has an estimated population in 2011 of 35,300 for a ratio of patients to providers of over 2,000 to one when the statewide average is 1,050 to one or a national benchmark of 631 to one. This project will expand the capacity of primary care to better accommodate the needs of the region and community. Our hospital currently serves the citizens in Hopkins, Delta, Rains and Franklin Counties. According to our strategic plan that was completed and presented in 2010, we were short 3-4 primary care providers, and since that time, have lost four primary care physicians. Our service area is in great need of access to primary care providers. The goal of this project is to increase PCP visits by 8400 by the end of DY 5. Challenges faced by the District include: a demand for primary care which far exceeds our ability to meet it, an aging medical staff which could result in even fewer PCPs and continued operating losses which make it difficult to finance recruitment efforts. Successful completion of the project will result in better meeting

the needs for primary care in our service area. The infusion of younger providers will offset possible near term retirements. Finally, an increase of patients to the clinic and also the hospital will improve our financial situation. This project will also lead to an increase in patient satisfaction as there will be an improvement in getting timely care, appointments and information. The overarching goal of the Northeast Texas Regional Healthcare Partnership is to move toward a realization of (1) improving the patient experience, (2) improving the health of the population, and (3) reducing the cost of healthcare. The project is related to regional goals in that it will help reduce the cost of care, improve access and quality of care. (Right Care, Right Time, Right Place).

Starting Point: Since the project is recruiting and employing two new primary care providers, the baseline for these PCPs is zero visits. The increase in visits to 4,200 per provider by DY5 is based on a benchmark for the average number of visits per primary care provider.

Rationale: Hopkins County Memorial Hospital (HCMH) is a 96 bed acute care district hospital with a 162.b corporation established to offer an employment option for physicians. Unfortunately, our physician group has declined by four PCPs over the last three years. Three left the community because they no longer wished to care for hospital inpatients and one left due to serious legal difficulties. With limited access to primary care providers, patients frequently receive services in urgent/emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care with a lack of appropriate follow-up. The shortage of PCPs also may further exacerbate the ability to receive appointments in a timely manner. This situation frequently leads to lower patient satisfaction scores in the area of timeliness of getting appointments with primary care providers. By increasing overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, increased patient satisfaction, appropriate utilization and reduced cost of services. HCMH has identified project option1.1.2.c, Expand Primary Care Clinic Staffing. We are not including options a. or b. because we currently have sufficient clinic space (option a.) and offer expanded clinic hours, including Saturday hours (option b) but do not have enough providers to meet community needs. This project is relevant to the RHP's Community Need Assessment (CN.1) insufficient access to primary health services. The first process milestone is to hire two primary care providers in DY2 (P-5) recorded by human resource documentation (P-5.1) with the baseline of zero visits per provider. The improvement milestone for DY3 will be an increase of clinic visits by 1,400 visits per provider (I-12) which will be documented through NextGen, the E.H.R. in the clinic setting (I-12.1). This will measure the increased volume of visits and is a method to assess the ability for the provider to increase the capacity to provide care. The improvement milestone for DY4 will be an increase of clinic visits by 2,800 visits per provider (1-12) over the baseline of visits again documented through NextGen (I-12.1). The improvement milestone for DY5 will be an increase of 4,200 visits per provider over the baseline documented through NextGen (I-12.1). This project was selected because with a severe lack of access to primary care, and patients are accessing the ED for non-urgent care increasing the cost of care. There is also a decrease in patient satisfaction as wait times increase to get an appointment with a PCP increases.

Core Project Components: HCMH has identified project option 1.1.2.c, Expand Primary Care Clinic Staffing. We are not including options a. or b. because we currently have sufficient clinic space (option a.) and offer expanded clinic hours, including Saturday hours (option b) but do not have enough providers to meet community needs.

Related Category 3 Outcome Measure: OD6 Patient Satisfaction
IT 6.1 Percent improvement over baseline of patient satisfaction scores
When adding new providers, it isn't enough just to make the resource available, the resource must be of value. One method of measuring the value of a provider is through patient satisfaction surveys. The addition of two PCPs will increase patient satisfaction in the areas of access to timely care, appointments and information. People with Medicaid, as others, rely on hospitals, especially the emergency rooms for general medical care. Currently, Medicaid patients are being treated in our Emergency Department for encounters that could be appropriate for the primary care setting. Under federal law, hospitals must triage anyone who shows up in the emergency rooms, regardless of their ability to pay. Thus, emergency departments often must treat many patients with conditions that do not warrant this highly expensive care. Much of this utilization is being driven by a shortage of PCPs. These patients cannot be screened and referred out due to the shortage of primary care providers and lack of available appointments. Once the PCPs have been added, the specified patients may be screened and referred to our primary care providers for care. This should lead to improved patient satisfaction, access to timely care and a more coordinate care effort as well as reducing the cost of care. This will affect and improve the health of our Medicaid population. A positive experience with the primary healthcare provider should encourage the patient to seek preventative care and build a relationship with the provider for proactive care.

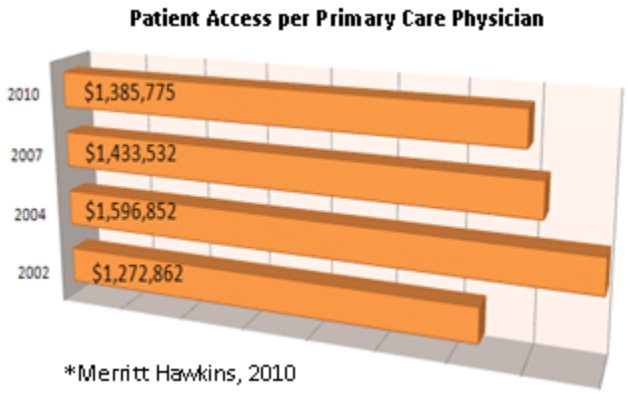
Relationship to other Projects: This project will provide evidence that expanding the existing primary care capacity 131037704.1.1 will lead to improved access to primary care as well as improving overall quality. It should reduce potentially preventable admissions. This will also impact our other DSRIP project 131037704.3.2 of cost reduction measures for CHF patients through implementing a cost accounting system 131037704.2.5. It also has the potential to improve patient satisfaction scores 131037704.3.1.

Relationship to Other Performing Providers' Projects in the RHP: Access to care is a pressing need in our regions. Hopkins County is part of the almost 90% of the East Texas region designated as medically underserved. Joining 14 other providers in augmenting the availability of primary care in Region 1 will have a significant impact in supporting the goals of our region.

Plan for Learning Collaborative: Hopkins County Memorial Hospital plans to participate in any RHP-wide learning collaborative offered to share ideas and best practices to attain the goal of increasing primary care provider access.

Project Valuation: The addition of two PCPs has multiple positive outcomes. It will increase volumes in both the clinic and hospital setting which shall have a positive impact on the

financial situation of the hospital district. Recruiting two primary care providers to a rural setting is exceedingly difficult especially as our nation and more particularly our state, faces a physician shortage. With our recent decline in primary care providers and an aging medical staff, the initiative to hire two additional PCPs is critical to maintain the viability of our hospital district. Our hospital district is one of the largest 3 employers in Hopkins County with over 600 employees. This project allows the hospital district to remain a sustainable employer and has a tremendous value to our community. Another aspect of increasing PCP access is being able to provide the basic healthcare needs of our community. Part of the hospital district's mission is to take care of the indigent population and almost 10% of our volume is self-pay and indigent so additional employed PCPs will give access to these patients in our service area. Often, the uninsured and indigent populations seek out primary care in the ED setting especially when there is a shortage of primary care physicians which is an expensive way to provide primary care. Expansion of existing primary care capacity will be valued on its ability to: (1) to increase access for our service area and specifically our Medicaid and indigent populations; (2) fulfill the hospital's mission and vision; (3) to improve the financial position of the hospital district; and (4) provide high quality of care in an economical setting by redirecting primary care from the emergency department to a clinic setting which better meets the needs for primary care in our service area. The value of adding of two PCPS to improve the viability of the hospital can also be based on a primary care provider, on our staff, on average, contributes as much as $1.5 million in revenue to our hospital. A study by Merritt Hawkins, a national physician search and consulting company that was conducted on "Physician Inpatient/Outpatient Revenue", supports that value. This study provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of the physician's affiliated hospital. This data demonstrates the impact of each additional primary care physician in which HCMH is adding two PCPs.



PROJECT* 131037704. *1.1	***1.1.2***	***1.1.2.c***	***EXPAND EXISTING PRIMARY CARE CAPACITY***
Hopkins County Memorial Hospital			131037704
Outcome Measure:OD-6	*131037704.3.1*	*3.1 IT 6.1*	Percent improvement over baseline in patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-5. Hire additional primary care providers (PCP) **Metric**: P-5.1. Documentation of increased number of providers 2 PCPs Goal: 2 PCPs hired Data Source: HR Documents Milestone 1 Estimated Incentive Payment*: $845.738*	**Milestone 2:** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric:** I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. 1400 visits per new provider Goal: 1400 visits incurred per PCP Data Source: Clinic EHR Milestone 2 Estimated Incentive Payment: $735,241	**Milestone 3:** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric:** I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. 2800 visits per new provider over baseline Goal: 2800 visits incurred per PCP over baseline Data Source: Clinic EHR Milestone 3 Estimated Incentive Payment: $699,144	**Milestone 4:** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric** I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. 4200 visits per new provider over baseline Goal: 4200 visits incurred per PCP over baseline Data Source: Clinic EHR Milestone 3 Estimated Incentive Payment: $623,648
Year 2 Estimated Milestone Bundle Amount: $845,738	Year 3 Estimated Milestone Bundle Amount: $735,241	Year 4 Estimated Milestone Bundle Amount: $699,144	Year 5 Estimated Milestone Bundle Amount: $623,648
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,903,771			

Project Option 1.1.2-Expand Existing Primary Care Capacity
Unique Project ID: 131037704.1.2 (Pass 2)
Preforming Provider Name/TPI: Hopkins County Memorial Hospital 131037704.

Project Abstract

Provider Description: Hopkins County Memorial Hospital (HCMH) is a 96 bed acute hospital located in Sulphur Springs with an estimated population of 18,000 and is the only hospital provider serving Hopkins County which has a population of approximately 30,000. Hopkins County Memorial Hospital currently employs primary care providers and has 13 physicians and 10 mid-levels.

Intervention(s): We will purchase clinic space and hire an additional primary care provider and staff to expand access to primary care.

Need for the Project: This project will allow HCMH the ability to provide appropriate care in a timely manner in the proper setting to the uninsured and underinsured population who currently seek primary health care in the Emergency Department as Level 1 and Level 2 patients.

Target Population: In the past two years, HCMH has had approximately 10,000 categorized as non-emergent (Level 1 and Level 2) patients and 3140 were self-pay, charity or uninsured/underinsured patients. We currently have 500 people on our Indigent Program. Our goal is to provide primary care to the low income through this additional access.

Category 1 or 2 Expended Patient Benefits: Increase access for the uninsured and underinsured population and increase visits in our new clinic by 3,000 by DY5.

Category 3 Outcomes: IT-9.4 Our goal is to reduce the Level 1 and Level 2 patients seen in the Emergency Department by 750 visits through DY5.

Project Narrative

Project Description: Hopkins County Memorial Hospital's (HCMH) goal is to expand patient access to primary care. More specifically, establish a primary care clinic targeted to the uninsured and underinsured population. Patients frequently receive services in urgent/emergent care settings for conditions that could be managed n a more coordinated manner in the primary care setting. Establishing a primary care clinic and expanding hours and staffing along with space will allow HCMH the ability to provide appropriate care in a timely manner in the proper setting. This project will address 1.1.2 (a), (b), and (c) as it will address space, hours and staffing. This increased primary care capacity will allow additional appointments available for the low income members of the community. The four year target goal is to increase patient access through this additional primary care clinic by 3000 visits over the baseline in primary care encounters. HCMH proposes to enhance primary care services by purchasing a building that is adjacent to other medical clinics near the hospital's campus. Clinic locations and cost of care can many times discourage people from obtaining health care proactively and instead wait until a chronic condition becomes acute episodes and then use the emergency department as a primary care provider. This location and additional access should result in more result in cost effective, coordinated care and allow for appropriate follow up care.

Starting Point: HCMH has experienced a change in the uninsured/indigent payer mix in the last few years with the economic downturn. As a result many patients rely on the Emergency

Department for their healthcare needs which is not designed to provide a coordinated plan of care. In the last two years, October 1, 2010 through September 30, 2012, HCMH has had approximately 10,000 categorized as non-emergent (Level 1 and Level 2) patients and 3140 were self-pay, charity or uninsured and under insured patients. The objective is to direct these patients after triage to the new clinic established to provide increased access to primary care. This primary care clinic is a new location and will be a new provider so the starting point is at zero visits and the goal is to increase patient encounters to over 3,000 visits in through DY5.
Rationale: Establishing an additional clinic will increase access for primary care for the uninsured and under insured population. The location of the clinic will be near the hospital campus which will make an easier transition of non-urgent ED patients to the nearby clinic. The increased access will also allow for patients to align themselves with a primary care provider resulting in better health outcomes, appropriate utilization and reduced costs for health care. Over time, patients would have an opportunity to build better habits to seek primary healthcare in the clinic setting rather than the Emergency Department.
Consistent with the overarching goals and vision of RHP 1, HCMH is moving towards realization of improving the patient experience of care, improving the health of the population and reducing the cost of care. NE Texas is an area where patients face many challenges in accessing primary care. Its population is older, poorer and less educated than the state average as evidenced in the RHP 1 community needs assessments. Expanding primary care access meets several community needs outlined by HHP 1 such an insufficient access to primary care services (CN.1), high costs to potently preventable hospitalizations (CN.4) and inappropriate emergency room utilization (CN.5).

Core Project Components: This project will address 1.1.2 (a), (b), and (c) as it will address space, hours and staffing.

Related Category 3 Outcome Measure: OD-9 Right Care, Right Setting
IT 9.4 Other outcome Improvement Target-Taking care of non-urgent patients in the appropriate setting : The focus of this project will be to redirect the level 1 and level 2 which is categorized as non-urgent Emergency Department patients from the Emergency Department setting to a primary care setting. Using a unique patient identifier, the patient will be followed from the ED setting to the newly established clinic setting to measure the impact of the increased primary care availability. Of particular focus will be to provide access to the uninsured and underinsured population in our county.

Relationship to other Projects: This project, the establishment of a primary care clinic 131037704.1.2 to provide the right care in the right setting, will also lead to improved access to primary care (131037704.1.1) as well as improving overall quality. This project is directly related to expanding existing primary care capacity. It will reduce non-urgent visits to the ED as well as reduce potentially preventable admissions. This will also be impacted by our other DSRIP project through implementing a cost accounting system 131037704.2.5. We will be able to quantify the actual cost of providing care to non-urgent patients in the Emergency Department. It also has the potential to improve patient satisfaction scores 131037704.3.1.

Relationship to Other Performing Providers' Projects in the RHP: Access to care is a pressing need in our regions. Hopkins County is part of the almost 90% of the East Texas region designated as medically underserved. Joining 14 other providers in augmenting the availability of primary care in Region 1 will have a significant impact in supporting the goals of our region. The focus will be on the uninsured and underinsured population which is also a need in RHP 1.

Plan for Learning Collaborative: Hopkins County Memorial Hospital plans to participate in any RHP-wide learning collaborative offered to share ideas and best practices to attain the goal of establishing more primary care provider access.

Project Valuation: The charges that have been associated with non-urgent patients (Level 1 and Level 2) in the last two years have been almost $2 million. Using a cost to charge ratio calculation, Emergency Department's costs were close to $825,500 for these non-urgent patients. A reduction of ED visits by 750 for underinsured and uninsured patients over a four year period, as stated in our goal, will decrease costs by approximately by $250,000. The investment in additional clinic space and staffing costs for DY3 through DY 5 will be a conservative estimated cost of $630,000. The establishment of a primary care facility for the uninsured and underinsured population will be valued on its ability to (1) increase access for our service area and specifically our self-pay and indigent populations; (2) provide high quality of care in an economical setting by redirecting primary care from the Emergency Department to a clinic setting which better meets the needs for primary care in our service area; and (3) reduce costs in the Emergency Department.

PROJECT* 131037704. *1.2	***1.1.2***	***1.1.2 A-C***	***EXPAND EXISTING PRIMARY CARE CAPACITY***	
Hopkins County Memorial Hospital				131037704
Outcome Measure:OD-9	*131037704.3.3*	*3.3 IT 9.4*	Other Outcome Improvements: Reduce Level 1 and Level 2 ED Encounters	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1. Establish additional primary care clinic **Metric**: P-1.1. Purchase of clinic building for access to primary care for the Uninsured and Underinsured patients Goal: Purchase one building Data Source: Purchase contract for building Milestone 2 Estimated Incentive Payment*: $51,3672.50* **Process Milestone 2**: P-5. Hire additional primary care provider and staff Metric:5.1 Hire additional PCP and staff to increase access Goal: One PCP and support staff hired Data Source: HR Documentation Milestone 2 Estimated Incentive Payment*: $51,362.50*	**Improvement Milestone 3:** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric:** I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 1750 visits over baseline Data Source: Clinic EHR Milestone 2 Estimated Incentive Payment: $121,806		**Improvement Milestone 4:** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric:** I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 2250 visits over baseline Data Source: Clinic EHR Milestone 3 Estimated Incentive Payment: $125,377	**Improvement Milestone 5:** I-12. Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric** I-12.1. Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 3000 visits over baseline Data Source: Clinic EHR Milestone 3 Estimated Incentive Payment: $108,190
Year 2 Estimated Milestone Bundle Amount: $102,725	Year 3 Estimated Milestone Bundle Amount: $121,806		Year 4 Estimated Milestone Bundle Amount: $125,377	Year 5 Estimated Milestone Bundle Amount: $108,190
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $458,098				

PROJECT 131037704. 1.2	***1.1.2***	***1.1.2 A-C***	***EXPAND EXISTING PRIMARY CARE CAPACITY***	
Hopkins County Memorial Hospital			131037704	
Outcome Measure:OD-9	*131037704.3.3*	*3.3 IT 9.4*	Other Outcome Improvements: Reduce Level 1 and Level 2 ED Encounters	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	

Project Option: 1.1.2 – Expand Existing Primary Care Capacity
Unique Project ID: 131038504.1.1 (Pass 1)
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville 131038504

Project Abstract

Provider Description: Hunt Memorial Hospital District is a public hospital system that provides acute, emergency, trauma, behavioral health, post acute and outpatient care in Hunt County. Hunt County has 86,129 residents, covering 882 square miles in Northeast Texas. Hunt Regional Medical Center (HRMC) is a 192 bed regional hospital operating within Hunt Memorial Hospital District in Greenville, Texas. In fiscal year 2011, HRMC had 29,820 inpatient days, 6,592 inpatient admissions and 2,804 observation visits. Hunt Memorial Hospital District also operates Hunt Regional Community Hospital, a 24 bed Critical Access Hospital located in Commerce, Texas. In 2011, Hunt Regional Community Hospital had 1,593 inpatient days and 355 inpatient admissions. Expanding primary care capacity is a transformative priority in RHP 1 and Hunt County. To maximize resources and existing primary care infrastructure, Hunt Regional Medical Center is proposing to collaborate DSRIP allocations with Hunt Regional Community Hospital. The project also proposes to partner with the Greenville Community Health Service Agency, a designated Federally Qualified Health Center (FQHC) to increase primary care capacity in Hunt County. The Greenville Community Health Service Agency currently provides primary care to the Greenville and Commerce population providing approximately 70,000 patient encounters in 2011.

Interventions: Hunt Regional Medical Center will partner with the Greenville Community Health Service Agency to increase primary care capacity in Hunt County. The project will increase primary care capacity by expanding clinic space, hours and primary care providers.

Need for the Project: Hunt County is significantly below state and national averages for primary care physicians. The population to primary care physician ratio in Hunt County in 2012 is 2,165:1, compared to Texas average of 1,050:1 (County Health Rankings and Roadmaps, 2012).

Target Population: The target population of this project is the Hunt County Medicaid and indigent population. In 2010, Hunt County had approximately 16,081 unduplicated Medicaid beneficiaries and 32,234 medically underserved residents.

Category 1 Expected Benefit: The project seeks to increase primary care encounters by 4800 encounters/year and increase the number of unique patients by 10% of baseline by demonstration year 5. The resulting increase in primary care access is expected to result in fewer non-emergent ED visits, potentially preventable admissions/readmissions and reduced total healthcare costs.

Category 3 Outcome: Expanding primary care capacity will increase access to preventative care. This project is expected to improve cholesterol screening and treatment to goal for patients with cardiovascular conditions.

Project Narrative

Project Description:
Goals

Primary Care is the cornerstone of preventative, high quality, patient centered care. Expanding primary care capacity contributes to the Northeast Texas regional goals of improving patient experience and health at a reduced cost by increasing primary care access to the medically underserved residents of Northeast Texas. Hunt Regional Medical Center's goal is to better treat the volume of patients needing primary care in the primary care setting with limited wait times. We also plan to re-integrate urgent care into the primary care setting by restructuring scheduling with dedicated appointments for urgent, same day visits.

Challenges

The largest challenge increasing primary care capacity is the current underdeveloped infrastructure. In Hunt County as elsewhere, low income, uninsured populations' are disproportionately medically disenfranchised. It will be a challenge to shift the populations focus to preventative, primary care in place of accessing the ED for healthcare or not seeking healthcare until a health crisis occurs. Expanding primary care capacity offers a proactive solution by designating resources to the medically disenfranchised population.

Delivery System Solution

Hunt Regional Medical Center will partner with the Greenville Community Health Service Agency, a designated Federal Qualified Health Center (FQHC) to increase primary care capacity in Hunt County. Our project strategies include: (1) increasing primary care providers, support staff and space at the existing Greenville Community Health Service Center, (2) adding an additional primary care clinic and staff in DY 4 in Quinlan at an existing Hunt Memorial Hospital District building, (3) offering patients primary care scheduling flexibility and the availability of urgent care visits by increasing clinic hours in the evening and on the weekend and (4) developing a primary care referral system between Hunt Regional Medical Center and Greenville Community Health Service Center for patients without a primary care provider.

Expected Outcome

The 5 year expected outcome for this project is to increase the number of primary care encounters by 4800/year by demonstration year 5, increase the number of unique patients by 10% of baseline, increase clinic hours and expand clinic locations to serve the southern part of Hunt County. Increasing primary care capacity is also expected to reduce non-emergent Emergency Department visits and readmissions.

Starting Point/Baseline:

Currently Hunt Regional Medical Center does not provide primary care. Our target population will focus on patients seen through our Emergency Department and/or admitted to the hospital who do not have a primary care provider. In calendar year 2011, the Emergency Department at Hunt Regional Medical Center had 11,594 uninsured patient encounters. Additional analysis revealed 5,899 of these encounters were level 1, 2, 3 visits which could be appropriate in the primary care setting. The uninsured ED population will serve as our target population of focus.

Rationale:

Access to primary care is associated with improved patient outcomes at a lower cost. Texas ranks 43rd in the ratio of primary care physicians to population (Texas Primary Care Coalition, 2008). Additionally, as identified in the Northeast Texas Regional Community Needs Assessment, Regional 1 has insufficient access to primary and specialty care services (CN. 1). Currently, the Greenville Community Health Service Agency is the only primary care clinic in Hunt County that consistently accepts new Medicaid and indigent patients.

The primary care provider shortage in Hunt County, a growing chronic illness population and increases in the un-insured population require rapid infrastructure development to increase primary care capacity. To address

the primary care deficit and resulting consequences, Hunt Regional Medical Center has selected to expand primary care capacity. Our project will encompass all the required core components of Project Option 1.1.2 including expanding (a) space, (b) hours, and (c) staffing as aforementioned in the project description.

The selected process milestones include building a primary care infrastructure including developing expansion plans and hiring and training primary care providers and staff. Improvement milestones include measuring increased access to primary care as evidenced by documentation of an increase in clinic volume and number of unique patients. Providing primary care is a completely new initiative for Hunt Regional Medical Center and does not duplicate any funding by the U.S. Department of Health and Human Services.

The proposed project will significantly enhance current primary care capacity to the Medicaid and indigent population in Hunt County. The proposed primary care project exceeds current funding by the U.S. Department of Health and Human Services for Federally Qualified Health Centers (FQHC). This project plans to provide additional primary care capacity that does not duplicate federally funded services. During demonstration year 2, Hunt Regional and the Community Health Service Agency (CHSA) will be developing the primary care capacity implementation plan when we will determine the management structure of the project. If the additional primary care staff and equipment are directly expended by CHSA, the agency will claim the expenses on their FQHC cost report. If the additional staff and supplies are expended by HRMC, the expenses will not be reflected on the CHSA cost report.

Related Category 3 Outcome Measure:
The desired end result of increasing primary care capacity is to actually improve primary, preventative care that will improve patient outcomes and reduce morbidity. To demonstrate a result of improved access to primary care, Hunt Regional Medical Center has selected Improvement Target 1.6, cholesterol management for patients with cardiovascular conditions. As identified in our regional community needs assessment, Region 1 has a higher than average rate of chronic conditions including cardiovascular disease (CN. 3). Additionally, DSHS estimates that the African American, Hispanic, and Caucasian population in East Texas have lower cholesterol screening rates than the state as a whole. According to DSHS, 83.5% of the Hispanic population in East Texas has not had their cholesterol checked within the last five years, compared to 57.5% of the statewide Hispanic population. For African Americans in East Texas, 45.3% have not had a cholesterol screening in the last five years, compared with 26.1% of the statewide African American population. 28.3% of Caucasians in East Texas had not had a cholesterol screening in five years, compared with 22.4% of the statewide Caucasian population (Texas Department of State Health Services, 2007).

Cholesterol is directly related to the development of cardiovascular disease which continues to be the leading cause of death in the United States. Cholesterol screening and reducing cholesterol directly reduces the occurrence of cardiovascular disease including heart attack, peripheral artery disease and stroke (U.S. Preventive Services Task Force, 2008). As hyperlipidemia does not have any symptoms, screening for and treating hyperlipidemia is critical. The disenfranchised, low-income population often does not seek primary care until a health event has already occurred. Therefore, increasing access to primary care and managing hyperlipidemia will improve health outcomes in low-income populations.

Relationship to Other Projects:
The expansion of primary care capacity will have a system wide impact and will support and reinforce other DSRIP projects. Improved primary care capacity will result in improved patient outcomes, care coordination and engagement at a reduced cost. Increasing primary care capacity relates to other projects including:

Category 1 Project
1310385-04.1.2 Increasing primary care capacity will support the telehealth project by increasing access to and timeliness of primary care to prevent chronic illness exacerbations.
1310385-04.1.3 Performance improvement and reporting capacity will support primary care by providing population and disease specific data to direct health outcome and patient experience interventions.
Category II Projects
1310385-04.2.1 Increasing access to primary care aligns with establishing a patient navigation program by offering patients with multiple medical and social needs a resource for primary, preventative care and follow-up.
1310385-04.2.2 Primary care capacity aligns with expanding care transitions by offering a primary care provider to manage health in the outpatient setting.
Category IV Projects
(4.1) Potentially Preventable Admissions
(4.2) 15-day Readmissions
(4.3) Potentially Preventable Complications
(4.4) Patient Centered Healthcare, including patient satisfaction and medication management
(4.5) Emergency Department

Relationship to Other Performing Providers Projects in RHP 1:
Increasing access to primary care is a regional priority. Many other regional partners have selected expanding primary care capacity including: the East Texas Medical Center system, Trinity Mother Frances Hospital, St. Michael Health System, Titus Regional Medical Center and The Burke Center. Hunt Regional Medical Center plans to participate in a regional expanding primary care learning collaborative to share best practices, new ideas and solutions.

Plan for Learning Collaborative:
Hunt Regional Medical Center will participate in the Region1 learning collaborative to expand primary care capacity. The learning collaborative will consist of sharing best practices through webinars and meetings to brainstorm ideas and present experiences from successful interventions. The region will establish quantifiable goals to drive project implementation and measure progression with supporting data. The learning collaborative will also identify implementation challenges and solutions.

Project Valuation:
There is consensus in the medical literature that increased access to primary care is associated with improved health outcomes and patient experience at a reduced cost. When people to not have access to primary care, they frequently seek healthcare in the Emergency Department with a greater severity of illness. Primary care deficits result in fragmented, episodic care which leads to an increase in hospitalizations, poorer health outcomes at a higher cost (Shih, 2012). Furthermore, for each 1% increase in primary care physicians, average-sized metropolitan areas experienced a decrease of 503 hospital admissions, 2,968 emergency room visits and 512 surgeries (Kravet, et al., 2008). Increasing the number of general practitioners in a state by 1 per 10,000 population is associated with a reduction in overall Medicare spending of $684 per beneficiary (Baicker and Chandra, 2004).

Hunt County is significantly below state and national averages for primary care physicians. The population to primary care physician ratio in Hunt County in 2012 is 2,165:1, compared to Texas average of 1,050:1 and National average of 631:1 (County Health Rankings and Roadmaps, 2012.) A 2012 Health InfoTechnics physician demand report, which utilizes data from the GMENAC Model based on a conservative level of 180

physicians per 100,000 population, shows Hunt County has a need for an additional 18 Internal Medicine physicians and 6 Family Practice physicians. Additionally, Hunt County is classified as a Medically Underserved Area/Population (U.S. Department of Health and Human Services, 2012).

The valuation approach for increasing primary care capacity is based on the lack of primary care infrastructure (CN. 1), the urgent need and the cost of development. In 2010, Hunt County had approximately 32,234 underserved individuals and 16,081 unduplicated Medicaid clients according to the Texas Department of State Health Services. In 2011, the HRMC Emergency Department had 5,899 Level 1, 2, 3 visits which could be appropriate in the primary care setting. Additionally, the town of Quinlan in Southern Hunt County has a severe primary care provider shortage. Expanding primary care capacity is a regional transformative priority in RHP 1 and Hunt County. To maximize resources and existing primary care infrastructure, Hunt Regional Medical Center is proposing to collaborate DSRIP allocations with Hunt Regional Community Hospital.

To address the primary care deficit, we propose to expand an existing primary care clinic in Greenville and add an additional primary care site in Quinlan. Based on statistics from our FQHC partner, one primary care provider can manage 4,800 encounters/year. The proposed valuation is based on the cost of adding two mid-level providers, a medical director, nurse/case managers, support staff, operational expenses, exam equipment, laboratory services, drugs and a renovation of an existing Quinlan medical office owned by Hunt Memorial Hospital District.

References:

Baicker, Katherine and Chandra, Amitabh. (2004). "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care." Health Affairs Web exclusive w4.184 (7 April 2004): 184-197.

Kravet, Steven J, et al. "Health Care Utilization and the Proportion of Primary Care Physicians." Amer J Med 121.2 (2008): 142-148. Available at:

Population Health Institute at the University of Wisconsin, County Health Rankings and Roadmaps, 2012. Available at: http://www.countyhealthrankings.org/#app/texas/2012/hunt/county/1/overall

Shih, Anthony, et al. (2008). "Organizing the U.S. Health Care Delivery System for High Performance." The Commonwealth Fund. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2770048/

Texas Department of State Health Services, 2010, Health Currents. Available at: http://www.dshs.state.tx.us/chs/healthcurrents/

Texas Primary Care Coalition (2008). The Primary Solution Mending Texas' Fractured Health Care System. Available at: http://www.taim.org/files/public/Primary-Solution.pdf

U.S. Department of Health and Human Services (2012). Health Professional Shortage Area. Available at: http://hpsafind.hrsa.gov/HPSASearch.aspx

U.S. Preventive Services Task Force. Screening for lipid disorders in adults: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jun. 13. Available at: http://www.uspreventiveservicestaskforce.org/uspstf08/lipid/lipidrs.htm

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE
131038504.1.1	1.1.2	1.1.2 A,B,C	EXPAND PRIMARY CARE CAPACITY

RHP Performing Provider: Hunt Regional Medical Center Greenville	PERFORMING PROVIDER TPI: 131038504

Related Category 3 Outcome Measure(s):	Category 3 IT identifier	Reference number	Outcome Measure
	131038504.3.1	IT- 1.6	Cholesterol management for patients with cardiovascular conditions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1] Establish additional/expand existing primary care clinics Metric 1 [P-1.1]: Number of additional hours; Develop an expansion plan with Greenville Community Health Service Agency to establish a baseline and target population, method to increase primary care encounters, increase current clinic hours, add a clinic in south Hunt County, and allot appointment slots for urgent visits and scheduling system that documents appointment request and appointment given. Baseline/Goal: Baseline hours of current clinic operation M-F 8:00-5:00 Goal: Increase evening hours on 2 nights/week and add 4 hours of weekend appointment availability Data Source: Documentation of expansion plan and appointment availability Milestone 1 Estimated Incentive Payment: $1,517,345	**Milestone 2 [P-5]** Hire/train additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline/Goal: Add 1 primary care provider at the Greenville Community Health Center (1 provider = 4800 encounters/year) and 1 LVN Data Source: Employment records Milestone 2 Estimated Incentive Payment *(maximum amount):* $827,671 **Milestone 3 [I-12]** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: 1 provider will perform 4800 primary care visits/year. Demonstrate improvement by a 50% increase in visits over baseline or 2400 visits per year.	**Milestone 4 [I-12]** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: 1 provider will perform 4800 primary care visits/year. Demonstrate improvement by a 75% increase in visits over baseline or 3600 visits per year. . Data Source: Electronic Health Record and claims data Milestone 4 Estimated Incentive Payment: $830,077 Metric 2 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Baseline/Goal: Demonstrate improvement by 5% increase in unique patients over baseline. Data Source: Electronic Health Record and claims data Milestone 4 Estimated Incentive Payment:	**Milestone 5 [I-12]** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: 1 provider will perform 4800 primary care visits/year. Demonstrate improvement by a 100% increase in visits over baseline or 4800 visits per year. Data Source: Electronic Health Record and claims data Milestone 5 Estimated Incentive Payment: $: 685,716 Metric 2 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Baseline/Goal: Demonstrate improvement by 10% increase in unique patients over baseline. Data Source: Electronic Health Record and claims data Milestone 5 Estimated Incentive Payment: $685,716

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.1.1	1.1.2	1.1.2 A,B,C	EXPAND PRIMARY CARE CAPACITY	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.1	Reference number IT- 1.6	Outcome Measure Cholesterol management for patients with cardiovascular conditions	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: Electronic Health Record and claims data Milestone 3 Estimated Incentive Payment: $827,671		$830,077	
Year 2 Estimated Milestone Bundle: Amount: $1,517,345	Year 3 Estimated Milestone Bundle Amount: $1,655,342		Year 4 Estimated Milestone Bundle Amount: $1,660,154	Year 5 Estimated Milestone Bundle Amount: $1,371,432
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $6,204,273				

Project Option: 1.7.2 – Introduce, Expand or Enhance Telemedicine/Telehealth
Implement Remote Patient Monitoring Programs for Diagnosis and/or Management of Care
Unique Project ID: 131038504.1.2 (Pass 2)
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Project Abstract

Provider Description: Hunt Regional Medical Center (HRMC) is a 192 bed regional hospital operating within Hunt Memorial Hospital District. Hunt Regional Medical Center is located in Greenville and serves 86,129 residents, covering 882 square miles in Hunt County. In fiscal year 2011 HRMC had 29,820 inpatient days, 6,592 inpatient admissions and 2,804 observation visits.

Interventions: This project will implement telehealth to provide remote patient monitoring and outpatient disease management to congestive heart failure patients in the home setting.

Need for the Project: Hunt County has a higher than average occurrence of chronic illnesses including cardiovascular disease. Hunt Regional Medical Center has a heart failure readmission rate of 25.7%, which is higher than the national average heart failure readmission rate of 24.8%. The telehealth program will improve access to and timeliness of healthcare services that is critical in chronic disease management.

Target Population: The target population of this project is the congestive heart failure population at HRMC including the Medicaid (12.3% payor mix) and indigent (14.7%) population. Based on 2011 volume statistics, we treat approximately 623 patients annually with a principal diagnosis of congestive heart failure. Additionally, Hunt Regional Medical Center plans to provide telehealth and remote patient management to 225 total patients throughout the demonstration including approximately 60 Medicaid and indigent patients that would directly benefit from the project.

Category 1 Expected Benefit: This project seeks to provide telehealth and remote patient management to 225 patients throughout the demonstration; 50 total patients within demonstration year 3, 75 total patients by demonstration year 4 and 100 total patients by demonstration year 5. Additional expected outcomes of the telehealth program are a reduction in ED visits and hospitalizations and improved access to healthcare, outcomes and patient experience.

Category 3 Outcome: The telehealth project is expected to reduce congestive heart failure 30 day readmissions.

Project Narrative

Project Description:
Goals
The overarching goal of the Northeast Texas Regional Healthcare Partnership (RHP 1) is to improve patient experience and health at a reduced cost. Consistent with that goal, a priority focus in Region 1 is implementing healthcare delivery projects to manage chronic illnesses. Telehealth programs have demonstrated prolonged survival, decreased hospitalizations and decreased total healthcare costs (Krumholz, et al., 2006).
The goals of the Hunt Regional Medical Center telehealth project are:

- Increased access to remote monitoring of patients with congestive heart failure

- Improved chronic disease outpatient management
- Increased care coordination, patient education and self-management skills
- Decreased episodes of hospitalization, Emergency Department utilization and hospital readmission of congestive heart failure patients

Challenges

There are multiple challenges to implementing a telehealth program. System related challenges include: (1) developing telehealth methodology, tools and patient self-management material (2) establishing a referral process for congestive heart failure patients from the hospital and outpatient setting (3) significant financial investment to purchase the tele-monitoring equipment and (4) hiring and training additional telehealth staff to manage the program. Patient related challenges include home telephone/internet access and variable levels of compliance with the program. The telehealth challenges will be completely explored and planned for during demonstration year 2 with project planning and development.

Delivery System Solution

According to the American Heart Association (Jessup, et al., 2009), close observation and follow-up is one of the single most effective tools to manage heart failure patients, yet is also the least used. Hunt Regional Medical Center will utilize the Institute for Healthcare Improvement 'Getting Started Guide: Improving Care for Patients with Heart Failure: Focus on Ambulatory Care' (2008) to model the telehealth program. The guide outlines the following key activities for ambulatory heart failure management:

- Optimizing evidenced based clinical care as established in the American College of Cardiology/American Heart Association Guidelines for the Diagnosis and Management of Heart Failure in Adults
- Medication reconciliation on a continual basis in every setting
- Segmenting care into two distinct phases including post discharge stabilization and ongoing management
- Engaging patients and families as partners in care
- Enhancing timely access to care
- Extending outpatient care to include a multidisciplinary team

Telehealth Program Planning and Development

The first step in developing the telehealth program will be to develop a detailed implementation plan outlining: (1) members of a multidisciplinary telehealth team, (2) identification of the target population, (3) outlining the referral process and (4) identification of the tools and resources required to provide telehealth. A multidisciplinary telehealth team will be assembled to provide oversight and direction of the telehealth program. Members will include: cardiology, family/internal medicine, home health and acute care nursing, case management, social work, pharmacy, respiratory therapy and dietician healthcare providers. The telehealth team will conduct a review of the literature to determine the target heart failure population that will benefit from telehealth. Congestive heart failure is categorized by stages based on the development and progression of heart failure and functional and structural deficits (Jessup, et al., 2009). The multidisciplinary team will establish a referral process including detailed medical and clinical staff education regarding the benefits of telehealth and the target population. The team will also develop an electronic screening tool compatible with the hospital electronic medical record to identify medically appropriate heart failure patients.

The telehealth team will place a great emphasis on developing tools and resources for engaging patients and caregivers in effective self-management and education. Effective self-management is imperative in this

population because heart failure patients often have multiple chronic conditions and social needs that create very complex medical management. Additionally, the heart failure disease trajectory is largely modified by adherence to medication and life style modifications. We will develop patient tools and resources that educate patients on:

- The heart failure disease process including risk factors, development, stages and resulting manifestations
- Signs and symptoms of exacerbation and corrective actions
- When and where to seek help
- Lifestyle modifications including diet, exercise and smoking cessation
- Heart failure medications- action, side effects and adverse reactions

The telehealth multidisciplinary team will evaluate and select a telehealth monitoring system that will enable clinical professionals to assess patients' clinical status from the patients' home by way of computer transmitted information. The telehealth team will also conduct performance improvement using the Plan Do Study Act (PDSA) quality model to guide and refine interventions.

Telehealth Program Components

Patients admitted to the telehealth program will be assessed for the optimization of evidence based recommendations of the American Heart Association (Jessup, et al., 2009):

- Identification of probable etiology of heart failure (and consideration of referral for further evaluation if unclear)
- Assessment of cardiac function, including last ejection fraction (EF)
- Statement of primarily systolic or diastolic heart failure (helpful to other health care providers)
- ACE-I or ARB prescribed for systolic dysfunction (EF<40 percent)
- The use of loop diuretics
- Last blood pressure (BP) and BP goal
- Dry weight baseline and current weight
- The avoidance of drugs known to adversely affect the clinical status of CHF including nonsteroidal anti-inflammatory drugs, most antiarrhythmic drugs and most calcium channel blocking drugs
- Tobacco free, or counsel if smoking
- Provision of patient education, including updated medications, diet and activity instructions, weight monitoring, and what to do if symptoms worsen
- Successful Teach Back of key patient education messages

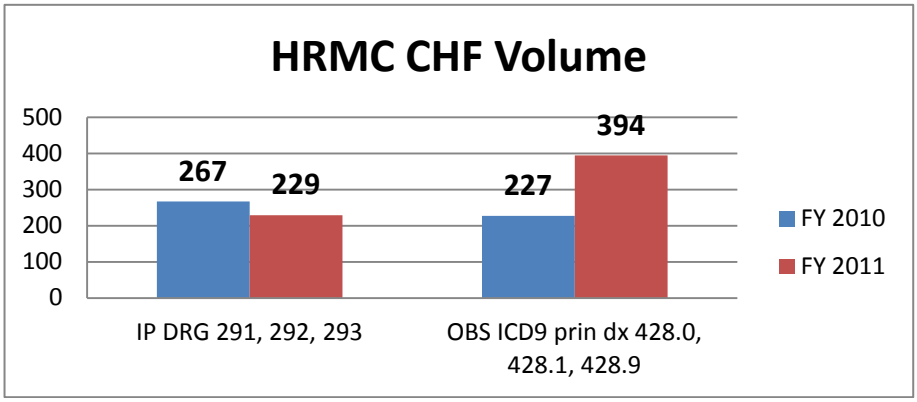
Patients will be instructed in how to use the tele-monitoring equipment placed in their home so that health assessment information is transmitted to a secure website for review. Patients will be assessed daily with a telephonic or electronic questionnaire that screens for changes in vital signs, weight, functional status and adherence to medications. This information will be stored and analyzed by automated decision support tools and a registered nurse. Alerts will be set for changes in vital signs, reporting of symptoms and non-adherence with medication. Telehealth patients with abnormal assessments will be identified for immediate intervention with a home visit by an advanced practice nurse.

Expected Outcome

The expected outcome of this project is the number of congestive heart failure telehealth patients will increase to 50 total patients within demonstration year 3, 75 total patients by demonstration year 4 and 100 total patients by demonstration year 5. It is expected the patients enrolled in the program will experience a

reduction in congestive heart failure readmissions. Additional expected outcomes of the telehealth program are a reduction in ED visits and hospitalizations and improved access to healthcare, outcomes and patient experience.

Starting Point:
Hunt Regional Medical Center currently does not offer telehealth or remote patient monitoring. Hunt Regional Medical Center congestive heart failure inpatient admissions and outpatient observation with CHF as the principal diagnosis volume statistics are as follows:



Rationale:
The proposed congestive heart failure telehealth project addresses several Northeast Texas Regional Healthcare Partnership (RHP 1) community needs including:

- CN.1: Insufficient access to primary and specialty care services
- CN.3: High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
- CN.4: High costs due to potentially preventable hospitalizations.
- CN.5: Inappropriate emergency room utilization.
- CN.6: Efficiency in and effectiveness of health care delivery.

Hunt County has significant barriers in healthcare delivery including deficits in primary care (CN. 1), that results in inappropriate ED utilization (CN. 5). The telehealth program would improve access to and timeliness of healthcare services that is critical in chronic disease management. Hunt County also has a higher than average occurrence of chronic illnesses including cardiovascular disease (CN. 3). All of these deficits result in a fragmented healthcare delivery system (CN. 6). Additionally, based on CMS discharge data during the baseline period of July 1, 2008- June 30, 2011 the HRMC congestive heart failure 30-day readmission rate of 25.7% was slightly higher than the national average of 24.8.

We have selected implementing telehealth because telehealth provides a valid, effective method to improve outcomes and care coordination for the chronically ill population. There is compelling evidence that telehealth in the heart failure population offers improved patient outcomes and experience with reduced readmissions and costs (Gambetta, Dunn, Nelson, Herron, and Arena, 2007). Additionally, we have focused on the congestive heart failure population because heart failure is the leading cause of hospital readmission with almost 30% of heart failure admissions readmitted with 30 days (Lloyd-Jones, et al., 2010).

The HRMC telehealth program encompasses all the required core components of Project Option 1.7.2 including: (a) implementing remote patient monitoring programs for diagnosis and/or management of care

and (b) quality improvement. The telehealth delivery mechanism selected to implement this project are home to monitoring center links that are used for cardiac and pulmonary home monitoring. Normal phone lines and/or internet connections are used to communicate directly between the patient and the monitoring center.

We have selected milestones and metrics for this project to measure progress in developing a telehealth program that will provide access to remote monitoring of patients with congestive heart failure and improve outpatient disease management. The *process milestones* include: (1) developing a remote patient monitoring program implementation plan based on evidence based models and community need including program materials, vendor agreements and staff training and (2) participating in a regional learning collaborative. The *improvement milestones* include measuring the number of heart failure patients in the telehealth program who did not have access to remote monitoring and case management before the program. Telehealth is a new service at Hunt Regional Medical Center and does not duplicate any funding by the U.S. Department of Health and Human Services.

Related Category 3 Outcome Measure:
To demonstrate improved health outcomes and experience while decreasing costs through the telehealth project, Hunt Regional Medical Center has selected Improvement Target 3.2- Congestive Heart Failure 30 day readmission rate. The objective of the telehealth program is to provide remote patient monitoring and disease management to congestive heart failure patients. According to the Institute for Healthcare Improvement (Amoah, B., et. al., 2008), enhanced outpatient multidisciplinary services have shown to reduce mortality by up to 20 percent and heart failure readmissions by 33 percent. We have selected this outcome improvement target because:

- Congestive heart failure is the specific target population of the proposed telehealth project
- Readmissions are a reliable and valid quality indictor of outpatient management
- Heart failure is a chronic, progressive, complex disease that requires intense outpatient management to avoid exacerbation.
- Hunt County residents have a higher than average occurrence of chronic illnesses including cardiovascular disease (CN. 3)

Relationship to Other Projects:
Telehealth is associated with improved patient outcomes and experience at a decreased cost. Implementing a telehealth program will serve a supporting and reinforcing role to other DSRIP projects including:
Category I Projects
1310385-04.1.1 Telehealth will support primary care by offering an alternative to hospitalization for continuous monitoring.
Category II Projects
1310385-04.2.1 Telehealth will support the patient navigation program by offering home monitoring and care in the ambulatory setting.
1310385-04.2.2 Telehealth relates to expanding care transitions by serving as a bridge from hospital to the home setting.
Category IV Projects
(4.1) Potentially Preventable Admissions
(4.2) 15-day Readmissions
(4.3) Potentially Preventable Complications
(4.4) Patient Centered Healthcare, including patient satisfaction and medication management
(4.5) Emergency Department

Relationship to Other Performing Providers' Projects in RHP 1:
Improving healthcare delivery, efficiency and patient outcomes with reduced costs and readmissions are regional priorities. Texoma Community Center in RHP 1 will also be implementing/expanding telehealth. Other regional projects focused on the chronic condition population with similar objectives include: expanding care transitions, chronic care management and patient navigation. Hunt Regional Medical Center plans to participate in a regional learning collaborative to share best practices, new ideas and solutions.

Plan for Learning Collaborative:
Hunt Regional Medical Center will participate in a regional learning collaborative hosted by the anchor. The learning collaborative will consist of sharing best practices through webinars and meetings to brainstorm ideas and present experiences from successful interventions. The region will establish quantifiable goals to measure implementation progression with supporting data and drive performance improvement. The learning collaborative will also identify implementation challenges and solutions.

Project Valuation:
In a pioneering study published in *The New England Journal of Medicine,* Jencks, Williams and Coleman (2009) discovered alarming statistics on the scope of hospital readmissions. Almost 20% of Medicare beneficiaries are readmitted to the hospital within 30 days from the index admission with 70% of these readmissions having a chronic medical condition. Furthermore, 50% of the readmissions did not have a claim for outpatient care, illustrating the fundamental lack of continuity of care. The cost of 1 in 5 unplanned hospital readmissions is estimated at 17.4 billion dollars per year. Furthermore according to the American Heart Association, "the prognosis after an index hospitalization for HF is ominous, with a 50% rate of readmission at 6 months" (Jessup, et al., 2009, p. 1996).

There is consensus in the medical literature, that telehealth results in improved patient outcomes, experience and morbidity/mortality with reduced hospitalizations and readmissions. The approach to valuation for the telehealth project is based on the need for rapid infrastructure development to address:

- A growing chronic disease population in Hunt County and RHP 1 (CN. 3)
- The overwhelming benefit of intensely managing patients with chronic illnesses in the outpatient setting
- The connectivity with other Hunt Regional Medical Center transformation projects including primary care, patient navigation and improving care transitions
- The cost of telehealth including: telehealth nursing and office staff for remote monitoring and home visits, an advanced practice nurse for outpatient management and treatment, self-management patient education and materials and tele-monitoring equipment.

References:
Amoah, B., Boutwell, A., Schall, M., Sevin, C., Shapiro, E., & Taylor, J. (2008). Getting started guide improving care for patients with heart failure: Focus on ambulatory care. Institute for Healthcare Improvement. Available at: http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Tools/GettingStartedGuideImprovingCareHeartFailureAmbulatoryCare.htm

Gambetta, M., Dunn, P., Nelson, D., Herron, B., & Arena, R. (2007). Impact of the implementation of telemanagement on a disease management program in an elderly heart failure cohort. *Progress in*

Cardiovascular Nursing, 22(4), 196-200. Available at: http://ezproxy.twu.edu:2052/login.aspx?direct=true&db=mnh&AN=18059196&site=ehost-live

Jessup, M., Abraham, W. T., Casey, D. E., Feldman, A. M., Francis, G. S., Ganiats, T. G., . . . Yancy, C. W. (2009). 2009 focused update: ACCF/AHA guidelines for the diagnosis and management of heart failure in adults: A report of the American college of cardiology Foundation/American heart association task force on practice guidelines: Developed in collaboration with the international society for heart and lung transplantation. *Circulation, 119*(14), 1977-2016. Available at: http://circ.ahajournals.org/content/119/14/1977.full

Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the medicare fee-for-service program. *The New England Journal of Medicine, 360*(14), 1418-1428. Available at: http://www.commonwealthfund.org/Publications/In-the-Literature/2009/Apr/Rehospitalizations-Among-Patients-in-the-Medicare-Fee-for-Service.aspx

Krumholz, H.M., Currie, P.M., Riegel, B., et al. (2006). A taxonomy for disease management: a scientific statement from the American Heart Association Disease Management Taxonomy Writing Group. *Circulation.* 114:1432–1445. Available at: http://circ.ahajournals.org/content/114/13/1432.full

Lloyd-Jones, D., Adams, R. J., Brown, T. M., Carnethon, M., Dai, S., De Simone, G., . . . Wylie-Rosett, J. (2010). Heart disease and stroke statistics--2010 update: A report from the American heart association. *Circulation, 121*(7), e46-e215. Available at: http://circ.ahajournals.org/content/121/7/948.full

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE
131038504.1.2	1.7.2	1.7.2	INTRODUCE, EXPAND OR ENHANCE TELEMEDICINE/TELEHEALTH

RHP Performing Provider:	PERFORMING PROVIDER TPI:
Hunt Regional Medical Center Greenville	131038504

Related Category 3 Outcome Measure(s):	Category 3 IT identifier	Reference number	Outcome Measure
	131038504.3.4	IT-3.2	Congestive Heart Failure 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-5] Implement remote patient monitoring program based on evidence based models and adapted to fit the needs of the population and local context. Metric 1 [P-5.1]: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. Baseline/Goal: Baseline: 0 patients currently receiving remote patient monitoring and case management telehealth services. Goal: Develop a CHF Telehealth implementation plan including: • Establish a multidisciplinary telehealth team • Identification of the target population Referral process • Development of patient tools and resources • Telehealth equipment vendor agreement • Telehealth staff employment and training Data Source: Program materials, multidisciplinary team meeting agenda/minutes, human resources/training records	**Milestone 3 [I-17]** Improved access to remote monitoring and case management in the congestive heart failure population. Metric 1 [I-17.2]: Improved access to health care services for residents of Hunt County, Texas, Health Professional Shortage Area (HPSA) who did not have remote monitoring and case management for the heart failure population before the program. a. Numerator: Number of unique congestive heart failure patients from Hunt County (HPSA), who receive remote monitoring and case management telehealth services. b. Denominator: Number of residents in HPSA Baseline/Goal: 50 total congestive heart failure patients over baseline will receive remote patient monitoring and case management. Data Source: EHR Milestone 3 Estimated Incentive Payment: $ 182,729.50	**Milestone 5 [I-17]** Improved access to remote monitoring and case management in the congestive heart failure population. Metric 1 [I-17.2]: Improved access to health care services for residents of Hunt County, Texas, Health Professional Shortage Area (HPSA) who did not have remote monitoring and case management for the heart failure population before the program. a. Numerator: Number of unique congestive heart failure patients from Hunt County (HPSA), who receive remote monitoring and case management telehealth services. b. Denominator: Number of residents in HPSA Baseline/Goal: 75 total congestive heart failure patients over baseline will receive remote patient monitoring and case management. Data Source: EHR Milestone 5 Estimated Incentive Payment: $ 186,702.50	**Milestone 7 [I-17]** Improved access to remote monitoring and case management in the congestive heart failure population. Metric 1 [I-17.2]: Improved access to health care services for residents of Hunt County, Texas, Health Professional Shortage Area (HPSA) who did not have remote monitoring and case management for the heart failure population before the program. a. Numerator: Number of unique congestive heart failure patients from Hunt County (HPSA), who receive remote monitoring and case management telehealth services. b. Denominator: Number of residents in HPSA Baseline/Goal: 100 total congestive heart failure patients over baseline will receive remote patient monitoring and case management. Data Source: EHR Milestone 7 Estimated Incentive Payment: $ 155,339.50

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE
131038504.1.2	1.7.2	1.7.2	INTRODUCE, EXPAND OR ENHANCE TELEMEDICINE/TELEHEALTH

RHP Performing Provider:	PERFORMING PROVIDER TPI:
Hunt Regional Medical Center Greenville	131038504

Related Category 3 Outcome Measure(s):	Category 3 IT identifier	Reference number	Outcome Measure
	131038504.3.4	IT-3.2	Congestive Heart Failure 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 Estimated Incentive Payment: $ 163,736 **Milestone 2: [P-11]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-11.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.	**Milestone 4: [P-11]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-11.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $ 182,729.50	**Milestone 6: [P-11]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-11.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $ 186,702.50	**Milestone 8: [P-11]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-11.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 155,339.50

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.1.2	1.7.2	1.7.2	INTRODUCE, EXPAND OR ENHANCE TELEMEDICINE/TELEHEALTH	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.4	Reference number IT-3.2	Outcome Measure Congestive Heart Failure 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment: $ 163,736				
Year 2 Estimated Milestone Bundle Amount: $ 327,472	Year 3 Estimated Milestone Bundle Amount: $ 365,459		Year 4 Estimated Milestone Bundle Amount: $ 373,405	Year 5 Estimated Milestone Bundle Amount: $ 310,679
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,377,015				

Project Option 1.10.2 – Enhance Performance Improvement and Reporting Capacity
Unique Project ID: 131038504.1.3 (Pass 3)
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Project Abstract

Provider Description: Hunt Regional Medical Center (HRMC) is a 192 bed regional hospital operating within Hunt Memorial Hospital District. Hunt Regional Medical Center is located in Greenville and serves 86,129 residents, covering 882 square miles in Hunt County. In fiscal year 2011 HRMC had 29,820 inpatient days, 6,592 inpatient admissions and 2,804 observation visits.

Interventions: Hunt Regional Medical Center will implement a project to enhance performance improvement and reporting capacity through people, processes and technology. We will hire two additional quality analysts to collect, analyze and perform performance improvement, purchase and install a data repository and interface to collect real-time data, develop a quality dashboard to measure improvement and select quality indicators including potentially preventable complications for rapid improvement.

Need for the Project: Texas ranked 46th out of the 50 states in healthcare performance indicators (Commonwealth Fund, 2009). Hunt County experiences higher than state and national quality indicators including mortality and morbidity and has higher than state averages of chronic conditions resulting in overall reduced health outcomes.

Target Population: The target population of this project is the total patient population of Hunt Regional Medical Center that provided 6,592 inpatient admissions and 2,804 observation visits in 2011. Hunt Regional is a public hospital with a payor mix of 12.3% Medicaid and 14.7% indigent.

Category 1 Expected Benefit: The expected outcome of this project is a robust quality program that utilizes real-time data to drive performance improvement. This project will benefit approximately 1800 Medicaid and indigent inpatient admissions, 750 Medicaid and indigent observation visits and 25,310 Medicaid and indigent Emergency Department visits annually. Additional expected outcomes are: adherence with evidence based care, improved care delivery consistency and the development of a hospital Quality Dashboard.

Category 3 Outcome: This project is expected to reduce the top 5 of the 10 highest volume potentially preventable complications.

Project Narrative

Project Description:

Goals

The overarching goal of the Northeast Texas Regional Healthcare Partnership (RHP 1) is to improve patient experience and health at a reduced cost. To realize the Triple Aim, healthcare providers must first identify and measure valid and reliable outcome measures associated with each domain. Consistent with that goal, Hunt Regional Medical Center has selected Performance Improvement and Reporting Capacity to implement the people, technology, processes and methodology to lead meaningful performance improvement.

The goals of the Hunt Regional Medical Center performance improvement and reporting capacity project are:

- Improve the quality of care at Hunt Regional Medical Center to deliver safe, effective, timely, patient-centered, equitable and efficient care
- Define quality metrics to measure each domain of the Triple Aim
- Accurately generate valid quality outcome data
- Identify our hospital specific potentially preventable complications rates and areas for improvement
- Prioritize quality indicators and establish a quality dashboard to track improvement
- Utilize the Plan, Do, Study, Act Quality Model to guide quality improvement

Challenges

One of the most challenging aspects of quality improvement is identifying quality metrics that reliably measure health outcomes and actually achieving and maintaining improvement. As quality reporting requirements have skyrocketed, a great emphasis has been placed on data collection and reporting activities versus fundamental performance improvement (Meyer, et al., 2012). It will be challenging to balance the increasing quality reporting requirements with intense, focused performance improvement.

Additional challenges are both people and technology related. People challenges include hiring and training clinical and data analytic staff to implement the project. Another challenge will be changing the culture at Hunt Regional to view quality improvement as process oriented versus associating errors and complications with an individual. Additionally, we currently have a limited number of quality reports in our electronic medical record system. The available reports are retrospective and technically challenging to format and interpret. The forthcoming project description outlines specific interventions and solutions to facilitate performance improvement and reporting capacity.

Delivery System Solution

Hunt Regional Medical Center is proposing to improve healthcare delivery quality and safety by enhancing performance improvement and reporting capacity through people, processes and technology. The project consists of three phases including: (1) Project Planning, (2) Implementation and (3) Ongoing Performance Improvement.

The first phase of the project includes project planning and aligning resources to implement the project. *Project planning* will include:

- Expanding our current Quality Department by hiring performance improvement clinical and data analyst staff.
- Training and educating the Quality Department and administrative staff on process improvement strategies, methodologies and culture.
- Expanding our quality measurement and reporting capacity by purchasing a data repository to provide quality reports and benchmarking capability by population characteristic, provider, disease specific or procedure related quality data sets
- Purchasing an interface to provide real-time data and the functionality to export quality data to stakeholders.

The second project phase focuses on implementing performance improvement methodology and quality measurement. We have modeled project implementation on the Institute for Healthcare Improvement Guide *to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost* (Stiefel and Nolan, 2012). As outlined in the guide, HRMC will begin *Implementation* by:

- Defining the population and sub-population

- Designing data collection systems to collect real time data that is used to drive continuous quality improvement
- Identifying our hospital specific potentially preventable complication rates
- Defining quality metrics to measure each Triple Aim domain including health, patient experience and cost
- Developing an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

The final phase of the project, *Ongoing Performance Improvement* includes performing the quality cycle and making adjustments and changes to healthcare delivery. We will select quality improvement interventions based on the Institute of Medicine's Aims for Improvement including: safety, effectiveness, timely, patient-centered equitable and efficient healthcare delivery (Institute of Medicine, 2001). Additionally, we assess our hospital specific complication and healthcare acquired condition rates and implement evidence based care bundles to improve the quality of care. According to the Institute for Healthcare Improvement a bundle is, "a small set of evidence-based interventions for a defined patient segment/population and care setting that, when implemented together, will result in significantly better outcomes than when implemented individually" (Resar, Griffin, Haraden and Nolan, 2012, p. 2).

Ongoing Performance Improvement

- Prioritizing quality indicators and establishing a quality dashboard to track improvement
- Establishing goals for performance improvement based on current performance and national benchmarking
- Utilizing the Plan, Do, Study, Act Quality Model with involvement of the front-line staff in the test area
- Redesigning care processes and workflows using evidence based bundles
- Analyzing quality data to assess if process changes are resulting in improved outcomes
- Refining quality improvement processes and workflows
- Building hard-wired processes into place to maintain improvement and consistency
- Educating clinical staff and stakeholders of the performance improvement activities, rationale, change in processes/workflows and results

<u>Expected Outcome</u>

The expected outcome of this project is a more robust quality program with the ability to identify, improve, monitor and maintain quality improvement. We also anticipate that data enhancement will provide the ability to evaluate cause and affect relationships for favorable health, patient-experience and cost outcomes. Additional expected outcomes are:

- A reduction in potentially preventable complications and healthcare acquired conditions
- Improved adherence and consistency with evidence based care
- Development of a hospital Quality Dashboard
- A quality culture change at HRMC with increased staff engagement in the quality improvement process and ownership of the quality priorities

Starting Point:

Hunt Regional Medical Center currently has a Quality Department. The Quality Department is currently handicapped by a lack of people and technology resources to provide real-time quality data. Because of these barriers, historically the quality functions have focused on regulatory quality activities. While we perform very

well in our current quality initiatives, we would like to expand adding quality improvement activities based on population specific indications.

Rationale:
Hunt Regional Medical Center strives to provide consistent, high-quality medical care to our patients and community. The proposed project addresses several Northeast Texas Regional Healthcare Partnership (RHP 1) community needs including:

- CN.3: High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
- CN.6: Efficiency in and effectiveness of health care delivery.

This project will be an invaluable tool to assess and manage the chronic condition population (CN. 3) by facilitating identification in outcome disparities for rapid improvement. The project will also improve efficiency and effectiveness in care delivery (CN. 6) by aiding focused performance improvement activities to add effectiveness and value to healthcare delivery.

We have selected this project, because it is an organizational priority to provide and maintain high quality, safe healthcare with the best possible outcomes. Measurement is a cornerstone of quality improvement and will enhance the existing quality functions at HRMC. The proposed project encompasses all the required core components of Project Option 1.10.2 including: (a) provide training and education to clinical and administrative staff on process improvement strategies, methodologies and culture, (b) develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement and (c) design data collection systems to collect real-time data that is used to drive continuous quality improvement.

The milestones and metrics for this project were chosen as a reflection of the purpose of the project, to improve performance improvement through people, processes and technology. The *process milestones* include: (1) hire/train quality improvement staff in well proven quality and efficiency improvement principles, tools and processes, (2) enhance or expand the organizational infrastructure and resources to store, analyze and share the patient experience data and/or quality measures data, as well as utilize them for quality improvement and (3) participate in a regional learning collaborative. The *improvement milestones* include: (1) implement quality improvement data systems, collection, and reporting capabilities as demonstrated by an increase in the number of reports generated and evidence how quality reports are used to drive rapid cycle performance improvement and (2) creating a quality dashboard that includes outcome and patient satisfaction measures and demonstration of how quality dashboard is used to drive rapid cycle performance improvement.

The proposed project will significantly enhance current performance improvement and reporting capacity at Hunt Regional Medical Center. The performance improvement, education and communication elements of the project exceed Meaningful Use funding by the U.S. Department of Health and Human Services.

Related Category 3 Outcome Measure:
To demonstrate improved health outcomes and experience while decreasing costs, Hunt Regional Medical Center has selected Improvement Target 4.1 Improvement in the risk adjusted Potentially Preventable Complications rate(s). Potentially preventable complications are an often preventable and unexpected result of hospitalization that was not present on admission (Fuller, McCullough, Bao and Averill, 2009). Focusing performance improvement activities on high risk, high occurrence complications will have a profound effect on improving care delivery safety and effectiveness. Reduced complications result in improved patient outcomes, mortality and patient experience, reduced length of stay, resource utilization and cost.

We have selected *Improvement in the risk adjusted Potentially Preventable Complications* rates because:

- Reducing complications and healthcare acquired conditions are a direct health outcome indicator of the objective of this project, to improve the quality of care delivery at HRMC.
- Hunt County ranks 155 out of 221 counties for health indicators in Texas (County Health Rankings and Roadmaps, 2012).
- The Hunt County premature death rate for persons who died younger than age 75 is 10,114/100,000 population compared to a state average of 7,186/100,000 (County Health Rankings and Roadmaps, 2012).
- Texas ranked 46th out of the 50 states in the Commonwealth Fund's 2009 State Scorecard on Health System Performance.
- The indigent and Medicaid population is more likely to access healthcare in the acute care setting versus outpatient, primary care. Overall, the low income population also receives less preventative care, be diagnosed at a more advanced stage of disease and receive less therapeutic care than the insured population (Code Red, 2006). Reducing complications will improve health disparities experienced by the low income population.

Relationship to Other Projects:

Quality and performance improvement is foundational and fundamental to all healthcare delivery strategies. Enhancing performance improvement and reporting capacity will serve a supporting and reinforcing role to other DSRIP projects including:

Category I Projects

1310385-04.1.1 Performance improvement and reporting capacity will support primary care by providing population and disease specific data to direct health outcome and patient experience interventions.

1310385-04.1.2 Performance improvement and reporting capacity will support and reinforce telehealth by providing quality data specific to the targeted heart failure population to guide interventions and improvement.

Category II Projects

1310385-04.2.1 Enhancing performance improvement and reporting capacity will support establishing a patient navigation program by facilitating health outcome and patient experience pattern identification in the high medical and social need population.

1310385-04.2.2 Enhancing performance improvement and reporting capacity will support expanding care transitions by providing quality data for pattern identification in the chronic condition population to guide interventions to reduce readmissions.

Category IV Projects

(4.1) Potentially Preventable Admissions
(4.2) 15-day Readmissions
(4.3) Potentially Preventable Complications
(4.4) Patient Centered Healthcare, including patient satisfaction and medication management
(4.5) Emergency Department

Relationship to Other Performing Providers' Projects in RHP 1:

Improving healthcare delivery, health outcomes and patient experience with reduced costs are regional priorities. Texoma Community Center in RHP 1 will also be enhancing performance improvement and reporting capacity. Enhanced performance improvement and reporting capacity is a central objective of all other healthcare transformation projects.

Hunt Regional Medical Center plans to participate in a regional learning collaborative to share best practices, new ideas and solutions.

Plan for Learning Collaborative:
Hunt Regional Medical Center will participate in a regional learning collaborative hosted by the RHP 1 anchor. The learning collaborative will consist of sharing best practices through webinars and meetings to brainstorm ideas and present experiences from successful interventions. The region will establish quantifiable goals to measure implementation progression with supporting data and drive performance improvement. The learning collaborative will also identify implementation challenges and solutions.

Project Valuation:
Enhanced performance improvement and reporting capacity are the foundational underpinnings of realizing the Triple Aim. The objective of this project is to improve the quality of care at Hunt Regional Medical Center to deliver safe, effective, timely, patient-centered, equitable and efficient care. HRMC will focus initially on reducing potentially preventable complications and healthcare acquired conditions. Potentially preventable complications are estimated to add nine percent to hospital inpatient costs, resulting in an approximately $88 billion dollar cost for the nation (Fuller, McCullough, Bao and Averill, 2009). Complications and hospital acquired conditions also result in patient harm, increased length of stay and increased morbidity and mortality. There is consensus in the medical literature that performance improvement centered on the Institute of Medicine's six aims of providing safe, effective, timely, patient-centered, equitable and efficient care will add value to healthcare resulting in improved outcomes and patient experience at a reduced cost.

The approach to valuation for the performance improvement and reporting capacity project is based on the need for rapid infrastructure development to address:

- Efficiency in and effectiveness of health care delivery (CN. 6).
- The overwhelming benefit of performance improvement to provide consistent, evidence based care to improve quality and safety.
- The connectivity with other Hunt Regional Medical Center transformation projects including primary care, tele health, patient navigation and improving care transitions.
- Enhancing performance improvement and reporting capacity is necessary to assess and act on the causality of healthcare disparities in the chronic condition population (CN. 3).
- The cost of enhanced performance improvement and reporting capacity including: the purchase of an electronic medical record interface and data repository, data analysts to support the technology and clinical analysts to apply the data to performance improvement activities.

References:
The Commonwealth Fund Commission on a High Performance Health System. (2008). Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008.
Available at: http://www.commonwealthfund.org/

Fuller, R., McCullough, E., Bao, M., Averill, R. (2009). Estimating the costs of potentially preventable hospital acquired complications. Healthcare financing reviews. 30:4. Available at:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2914724/

Institute of Medicine, Committee on Quality of Health Care in America. Crossing the Quality Chasm—A New Health System for the 21st Century. Washington, DC: National Academy Press, 2001. Available at:

http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

Meyer GS, Nelson EC, Pryor DB, James B, Swensen SJ, Kaplan GS, Weissberg JI, Bisognano M, Yates GR, Hunt GC. More quality measures versus measuring what matters: A call for balance and parsimony. BMJ Quality and Safety. 2012 Oct 24;21:964-968. Available at: http://www.ihi.org/Pages/default.aspx

Population Health Institute at the University of Wisconsin, County Health Rankings and Roadmaps, 2012. Available at: http://www.countyhealthrankings.org

Resar R, Griffin FA, Haraden C, Nolan TW. *Using Care Bundles to Improve Health Care Quality*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. Available at: http://www.ihi.org/Pages/default.aspx

Stiefel M, Nolan K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. Available at: http://www.ihi.org/Pages/default.aspx

Task Force for Access to Health Care in Texas. (2006). Code Red. The Critical Condition of Health in Texas. Available at: http://www.coderedtexas.org/

Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.1.3	1.10.2	1.10.2 A,B,C	Enhance Performance Improvement and Reporting Capacity	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.5	Reference number IT-4.1	Outcome Measure Improvement in risk adjusted Potentially Preventable Complications rate(s)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-6] Hire/train quality improvement staff in well proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends). Metric 1 [P-6.1]: Increase Number of staff trained in quality and efficiency improvement principles. a. Numerator: Number of staff trained b. Denominator: Total number of staff Baseline/Goal: We will hire and train 1 clinical quality nurse and 1 data analyst in quality and efficiency improvement principles, tools and processes. Data Source: HR, training programs Milestone 1 Estimated Incentive Payment: $ 73,952.67 **Milestone 2 [P-5]**	**Milestone 4 [I-7]** Implement quality improvement data systems, collection, and reporting capabilities. Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems Baseline/Goal: We will increase the number of quality data reports generated through quality improvement data systems to capture real-time performance measures for 2 potentially preventable complications. . Data Source: Quality improvement data systems Metric 2 [I-7.2]: Demonstrate how quality reports are used to drive rapid cycle performance improvement. Baseline/Goal: We will conduct PDSA cycles/performance improvement activities for 2 potentiality preventable	**Milestone 6 [I-8]** Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 1 [I-8.1]: Submission of quality dashboard or scorecard Baseline/Goal: We will develop a quality dashboard with (6) metrics to measure each domain of the Triple Aim including: health outcomes, patient experience and cost. Data Source: Quality improvement data systems Metric 2 [I-8.2]: Demonstration of how quality dashboard is used to drive rapid cycle performance improvement Baseline/Goal: Develop (2) PDSA cycles/performance improvement	**Milestone 8 [I-8]** Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 1 [I-8.1]: Submission of quality dashboard or scorecard Baseline/Goal: We will develop a quality dashboard with (9) metrics to measure each domain of the Triple Aim including: health outcomes, patient experience and cost. Data Source: Quality improvement data systems Metric 2 [I-8.2]: Demonstration of how quality dashboard is used to drive rapid cycle performance improvement Baseline/Goal: Develop (4) PDSA cycles/performance improvement

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.1.3	1.10.2	1.10.2 A,B,C	Enhance Performance Improvement and Reporting Capacity	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.5	Reference number IT-4.1	Outcome Measure Improvement in risk adjusted Potentially Preventable Complications rate(s)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Enhance or expand the organizational infrastructure and resources to store, analyze and share the patient experience data and/or quality measures data, as well as utilize them for quality improvement. Metric 1 [P-5.1]: Increased collection of patient experience and/or quality measures data Baseline/Goal: We will collect new quality measures (1) and patient experience measures (1). . Data Source: Documentation of methodology for patient experience and or quality measures data collection and reporting. Milestone 2 Estimated Incentive Payment: $ 73,952.67 **Milestone 3: [P-9]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP	complication measures that were designed and implemented based on the data in the reports. Data Source: Documentation from quality improvement office Milestone 4 Estimated Incentive Payment: $ 123,796.50 **Milestone 5: [P-9]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-9.1] Participate in semi-annual face to face meetings or seminars organized by the RHP.		activities that use data from the Quality Dashboard to inform design and implementation of a process improvement. Data Source: Documentation from Quality Department. Milestone 6 Estimated Incentive Payment: $ 126,489.50 **Milestone 7: [P-9]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-9.1] Participate in semi-annual face to face meetings or seminars organized by the	activities that use data from the Quality Dashboard to inform design and implementation of a process improvement. Data Source: Documentation from Quality Department. Milestone 8 Estimated Incentive Payment: $ 105,240 **Milestone 9: [P-9]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-9.1] Participate in semi-annual face to face meetings or seminars organized by the

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.1.3	1.10.2	1.10.2 A,B,C	Enhance Performance Improvement and Reporting Capacity	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.5	Reference number IT-4.1	Outcome Measure Improvement in risk adjusted Potentially Preventable Complications rate(s)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-9.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment: $ 73,952.67	Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $123,796.50	RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $ 126,489.50	RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 9 Estimated Incentive Payment: $ 105,240

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.1.3	1.10.2	1.10.2 A,B,C	Enhance Performance Improvement and Reporting Capacity	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.5	Reference number IT-4.1	Outcome Measure Improvement in risk adjusted Potentially Preventable Complications rate(s)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $ 221,858	Year 3 Estimated Milestone Bundle Amount: $ 247,593		Year 4 Estimated Milestone Bundle Amount: $ 252,979	Year 5 Estimated Milestone Bundle Amount: $ 210,480
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 932,910				

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 136140407.1.1 (PASS 1)
Performing Provider Name/TPI: ETMC Mt. Vernon 136140407

Project Abstract

Provider: East Texas Medical Center Mt. Vernon (ETMC) is a 49-bed, full-service hospital dedicated to serving the Franklin County area with advanced diagnostics, medical and surgical care, and outpatient services. ETMC's primary service area is Franklin County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 120,272.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends and adding needed physician and support hours.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Northern Region (Camp, Franklin, Red River, Wood, and Upshur Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 582 new clinic patients with a Medicaid and indigent share of at least 25%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by an 8% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and staffing. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by an 8% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions

are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include additional physician hours as well as needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 10,089 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal,

suggests that “two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent).”

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It’s Not At Their Doctor’s Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC’s ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and clinic staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (136140407.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and staffing (136140407.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (136140407.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

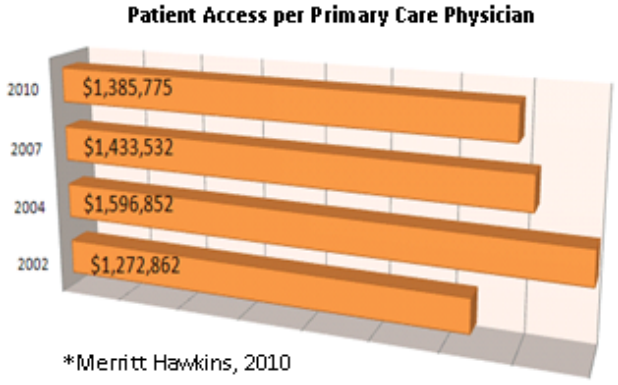
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $164,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $146,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		582
ED visits / year / person*		0.45
Potential ED Visits		262
ED Visits Reduced @ 15%		39
Avg ED Payment		$425
ED Savings	**$**	**16,722**
IP Admissions / year / person*		0.11
Potential IP Admissions		66
Admissions Reduced @ 18%		12
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**147,387**
Total Estimated Savings	**$**	**164,109**



136140407.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Mt. Vernon			*136140407*
Related Category 3 Outcome Measure(s):	***136140407.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $115,136	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 4% over baseline of 10,089 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $125,607	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 6% over baseline of 10,089 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $125,972	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 8% over baseline of 10,089 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $104,064
Year 2 Estimated Total DSRIP: $115,136	Year 3 Estimated Total DSRIP: $125,607	Year 4 Estimated Total DSRIP: $125,972	Year 5 Estimated Total DSRIP: $104,064
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$470,780***			

Project Option: 1.12 – Enhance service availability of appropriate levels of behavioral health care.
Unique Project ID Number: 136367307.1.1
Performing Provider Name/TPI: Burke Center 136367307

Project Abstract

Provider: Under Texas statutes, the Burke Center is designated as a Community Mental Health and Mental Retardation Center. Burke Center provides community-based behavioral health, early intervention and intellectual disability services to persons living in a twelve county catchment area. Ten of these counties (Angelina, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler) are contained in RHP 2. The remaining two (Houston and Trinity) are contained in RHP 1. This service area stretches over 10,000 square miles and contains 370,000 persons. It has been designated a mental health professional shortage area.

Project: This project will expand the capacity of the Burke Center to serve more children and adults with mental illness. We will provide outpatient psychiatric care, therapy, medication services and patient education as needed.

Need for the Project: With current funding, services are limited to a stringent "priority population" as defined by DSHS and there is a waiting list of eligible persons. Many others with serious mental illness seek care but are denied access as they do not meet the target population criteria. With this project, we will expand our capacity by 180 persons per year over baseline by DY5 to address the needs of those with serious mental illness.

Target Population: The target population for this project will be persons on the wait list for care and others with a significant mental illness not meeting current eligibility criteria. The vast majority will be Medicaid or medically indigent.

Category 1 patient benefits: Service volume will increase over baseline by 10% (60 individuals) in DY 3, 20% (120 individuals) in DY 4 and 30% (180 individuals) by DY 5. This will reflect the fact that more people get timely care.

Category 3 outcomes: IT-6.1 improved access to care will be reflected in improved patient satisfaction in receiving timely care, appointments, and information. The Center will participate in a statewide learning collaborative to identify and implement other relevant measures and strategies for data collection through HIEs or other sources.

Project Narrative

Projection Description: Project option 1.12 – Enhance service availability of appropriate levels of behavioral health care will expand the capacity of primary behavioral health care to better accommodate the needs of the regional patient population and community, so that patients

have enhanced access to services allowing them to receive the right care at the right time in the right setting. This project will expand and enhance system access points in a rural medically underserved area. This project will provide specialized services to complex behavioral health populations such as people with severe mental illnesses in order to meet this population's complex behavioral health needs.

Project Goals:

1.) Provide services to more patients
2.) Expand, enhance and improve access points
3.) Decrease travel distance for patients

Anticipated Challenges: Challenges include having a limited number of specialized providers to serve a growing population of medically indigent individuals and having a limited array of treatment modalities and resources for which to meet the needs of individuals with multiple concomitant issues. This often results in services not being offered to those in need as evidenced by the large waiting list for services and even larger number of individuals who simply are turned away to seek services elsewhere. This project addresses these challenges by creating positions and appointment availability to meet these needs. Psychiatrists, mid-level practitioners, therapists, peer specialists, and support staff will provide fundamental specialized services to cover the needs of these individuals.

The 5-Year expected outcomes: The expected 5-year outcome is the expansion of the number of patients served by 30% and an improvement of their satisfaction with services. This project relates to regional mission by improving access to care and health outcomes.

Regional goals:

- Improve the health of our region by expanding and coordinating access to specialty care services and chronic disease management
- Improve the quality of patient care through data collection, analysis, reporting and continuous process improvement

Starting Point/Baseline: Burke Center services are limited by contractual agreement with the Department of State Health Services (DSHS) to persons in crisis or those meeting "priority population" or the more stringent "target population" diagnoses, per DSHS. Target Population diagnoses include individuals with schizophrenic disorders (32% of population served), bi-polar disorders (42%), and major depressive disorder (26%) with a global assessment of functioning below 50 in our adult population. There is a waiting list for adult outpatient services and large a number of individuals are referred to already strained and limited community resources. Resources are inadequate to provide care for persons with significant mental illnesses outside the "priority population" definitions. Most of the individuals referred or placed on the waiting list have limited funds to pay for services in the community. By opening up capacity individuals placed on the waitlist, those referred out for services, and other community members seeking help outside the target population will have the opportunity to receive behavioral health services. We are currently providing services to approximately 600 individuals each year in Houston and Trinity Counties. ~~1950 adults and 330 children/adolescents. We anticipate this to~~

~~equate to approximately 800 individuals per year being serviced in some capacity for mental health concerns.~~ By the end of DY 5, we anticipate that we will have expanded our capacity by 30%, serving 180 additional persons each year.

Rationale: The selected project is 1.12 Enhance Service Availability of appropriate levels of behavioral health care and the project option is 1.12.4 other project Option.

Individuals may experience barriers in accessing primary behavioral health care services secondary to lack of transportation, lack of financial resources, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the behavioral health care setting. By enhancing access points, available appointment times, individual's awareness of available services and overall primary care capacity, patients and their families will align themselves with the behavioral health care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced expense to patients.

Core options include expanding behavioral health care clinic location, expand primary behavioral health clinic hours, and expand primary behavioral health care clinic staffing, and adding peer specialist service. As mentioned earlier we have a high level of need in our service area as evidenced by the number of individuals who are currently on a waitlist as well as the high number of individuals referred for services who do not meet our target diagnostic population. We also have individuals in the community who do not seek our services simply because they know they will not meet our criterion for services.

Several DY 2 Process Metrics and DY 3 Process Milestones will be chosen to show the breadth and depth of the program. Our Process Milestones include the expansion of primary clinics and the number of providers at these expanded and extended clinics. Milestone P-6 establishes behavioral health services in new community-based settings in underserved areas. The Process Metric P-6.1 expands the number of additional clinics. The proposed process includes the addition of one clinic in a community that does not currently have a primary behavioral health care office. This provides opportunities to those with limited means of transportation and increases the chances for them to actually receive this needed service.

Process Milestone P-5 will be used to expand hours at two satellite clinics and Process Millstone P-4 to train/hire additional specialty providers and staff to provide services to this non/under-served population. Process Metric P-5.1 will be used to establish the most efficacious and client friendly number of hours of operation for the expanded hours. Process Metric P-4.1 will be used to establish the number of staff/providers/peers to hire and train to serve this population. Services to individuals with behavioral health problems as well as those with severe mental illness require specialized providers in the provision of this service. Psychiatrists, mid-level prescribers and licensed professionals of the healing arts as well as support staff for these individuals are required.

Improvement Milestone I-X will be used to increase primary behavioral health care clinic volume of visits and evidence of improved access for individuals seeking services. Improvement Metric I-X.1 will document the number of increased visits and demonstrate improvement over the reporting period. The customized milestone was determined to be the best option to allow us to focus on the improvement most necessary in this community, that of improved access to service as evidenced by the number of individuals using the service.

Unique Community Need Identification numbers:

CN.2
CN.6

Expansion or Enhancement: This project will allow the Center to serve significantly more individuals and to serve individuals who are currently ineligible for our services due to not meeting priority population as per DSHS. It will also allow us to provide services in rural areas not currently served, thus increasing access.

Related Category 3 Outcome Measures: Our primary outcome is OD-6 Patient Satisfaction. The expansion of primary services via expanded clinic hours and increased number of providers will significantly improve the quality of life of the individuals served. Baseline satisfaction scores will be collected as the standalone measure. IT 6.1. will be used to show percent improvement in access so individuals receive timely care, appointments, and information. The category 3 Process Milestones are designed to enable us to develop an implementation plan; establish baseline rates; and continually improve services.

It is well known the national supply of behavioral healthcare ~~primary care~~ does not meet the demand for mental health ~~primary care~~ services for the Medicaid and indigent population. Moreover, it is a goal of health care improvement to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. RHPs are in real need of expanding behavioral health ~~primary~~ care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients, and to assure these services are provided in a manner that meets patient satisfaction.

Relationship to Other Projects: This project is related to Category 2.18 Recruit, Train, and Support consumers of mental health services to provide peer support services and to Category 1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth. Both of these projects will be focusing on the expansion of service delivery in the medically underserved service area; one in the form of identifying individuals with health risks who need peer services and the other to provide required modality of reaching clients in satellite locations. The increase in service expansion through the addition of extended/expanded hours and specialized staff will open the door for more people who need peer services and telehealth/telemedicine is an essential conduit to reach these individuals in their own communities. Having expanded hours as well as specialized staff is crucial to these projects.

Relationship to Other Performing Providers' Projects in the RHP: This Section Intentionally Left Blank

Plan for Learning Collaborative: Many of the projects chosen by RHP 1 shift from traditional models of care delivery to more patient-focused, community-based, coordinated points of access and care transitions. As the region's providers implement these new models of care delivery it is important that we share and learn from each other's successes and challenges. Our collective learning will help in the transformation of our region towards better health and improved coordination. Our shared learning will also help in the identification of best practices and enhance the equity of services across the region.

Project Valuation: The need for strategies to improve access to care via expanded service times as well as specialized providers is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality, overuse of emergency departments, and poor health outcomes as severity of behavioral health disorders increase.

The target population for all services is largely uninsured individuals or those with Medicaid/Medicare for whom local specialty providers are not available.

One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness. We are anticipating increasing our total number served through our Expansion of Behavioral Healthcare project. Individuals having a medical need for behavioral health services will receive targeted support services from specialized service providers. ~~In the end individuals in our target population will have better health risk outcomes which impact the number of primary care visits they would seek throughout the year.~~

136367307.1.1	*1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE*	*1.12.4*	*ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE*	
		Burke Center		*136367307*
Related Category 3 Outcome Measure(s): OD-6	136367307.3.1	*IT-6.1*	*Are getting timely care, appointments, and information. Percent Improvement Over Baseline of Patient Satisfaction Scores.*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone P-6: Establish behavioral health services in new community-based settings in underserved areas. **Metric 1 P-6.1**. Number of new community-based settings where services are delivered. Baseline/Goal: The number of current locations and the number of patients served. **Goal:** Add one additional service site and increase the number of patients served. **Data Source:** Internal count of operating hours and number of patients served. Milestone Estimated Incentive Payment *(maximum amount):* $141,998 *Milestone P-5: Establish extended hours.*	**Milestone P-4** :Hire and train staff to operate and manage projects selected. **Metric P-4.1** Number of staff secured and trained. **Baseline/Goal:** The number of current providers and staff. **Goal:** At least one additional prescriber, one support staff, one therapist, and one case worker will be hired. **Data Source:** Internal count of current staff allocation. **Milestone Estimated Incentive Payment *(maximum amount):*** $155,940 **Milestone I-X:** Increase primary care clinic volume of visits and evidence of improved access for individuals seeking service.		**Milestone I-X:** Increase primary care clinic volume of visits and evidence of improved access for individuals seeking service. **Metric IT-X.1:** Documentation of Increased number of visits. Demonstrate improvement over prior reporting period. **Goal:** Increase the number of visits over the baseline reporting period by 20% (120 individuals). **Data Source:** Information pulled from agencies EHR. **Milestone Estimated Incentive Payment (maximum amount):** Milestone Estimated Incentive Payment (maximum amount): $333,632	**Milestone I-X:** Increase primary care clinic volume of visits and evidence of improved access for individuals seeking service. **Metric I-X.1:** Documentation of Increased number of visits. Demonstrate improvement over prior reporting period. **Goal:** Increase the number of visits over the baseline reporting period by 30% (180 individuals). **Data Source:** Information pulled from agencies EHR. **Milestone Estimated Incentive Payment (maximum amount):** $322,351

136367307.1.1	***1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE***	***1.12.4***	***ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE***	
Burke Center				*136367307*
Related Category 3 Outcome Measure(s): OD-6	136367307.3.1	*IT-6.1*	*Are getting timely care, appointments, and information. Percent Improvement Over Baseline of Patient Satisfaction Scores.*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 P-5.1. Number of areas prioritized for intervention with options in operation. *Baseline/Goal: The number of current hours of service for these locations.* *Goal: Add an additional 12-14 hours of operation in existing sites* *Data Source: Internal count of operating hours.* *Milestone Estimated Incentive Payment (maximum amount): $141,998*	**Metric I-X.1:** Documentation of Increased number of visits. Demonstrate improvement over prior reporting period. **Goal:** Increase the number of visits over the baseline reporting period by 10% (60indivduals). **Data Source:** Information pulled from agencies EHR. Milestone Estimated Incentive Payment *(maximum amount):* $155,940		
Year 2 Estimated Milestone Bundle Amount*:* $283,996	Year 3 Estimated Milestone Bundle Amount: $311,880	Year 4 Estimated Milestone Bundle Amount: $ 333,632	Year 5 Estimated Milestone Bundle Amount: $322,351
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,251,859			

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 137319306.1.1 (PASS 1)
Performing Provider Name/TPI: ETMC Crockett 137319306

Project Abstract

Provider: East Texas Medical Center Crockett (ETMC) is a 49-bed, full-service hospital dedicated to serving the Houston County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Houston County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 94,915.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, recruiting a family practice physician and a pediatrician, and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Southern Region (Anderson, Houston, and Trinity Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 2,177 new clinic patients with a Medicaid and indigent share of at least 25%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and recruiting a family practice physician and a pediatrician. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by a 15% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include a family practice physician, a pediatrician, and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services and pediatrics. The ETMC Southern Region is currently underserved by 23 primary care physicians—including a shortage of 5 family practice physicians and 7 pediatricians.

Service Area Population 94,915							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7		29.5	28	23	(5)
Geriatric Medicine	0	0	2.6	2.6	2	3	1
Internal Medicine	28.8	17.6		23.2	22	11	(11)
Pediatrics	12.8	12.9		12.9	12	5	(7)
Primary Care Total					**65**	**42**	**(23)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 27,100 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC's ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care

expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends and recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours and clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (137319306.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (137319306.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (137319306.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

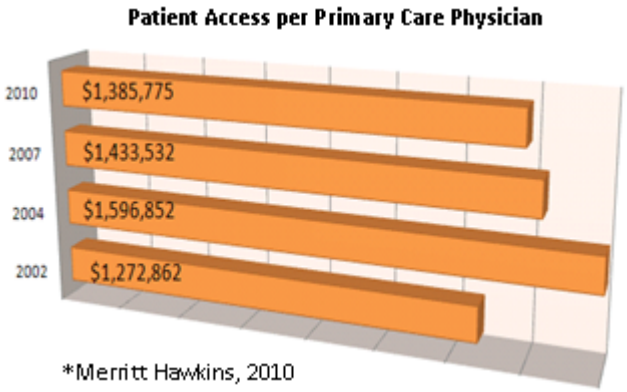
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $615,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $522,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		2,177
ED visits / year / person		0.45
Potential ED Visits		982
ED Visits Reduced @ 15%		147
Avg ED Payment		$425
ED Savings	**$**	**62,602**
IP Admissions / year / person		0.11
Potential IP Admissions		248
Admissions Reduced @ 18%		45
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**551,781**
Total Estimated Savings	**$**	**614,383**



137319306.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Crockett			*137319306*
Related Category 3 Outcome Measure(s):	***137319306.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $411,360	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 5% over baseline of 27,100 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $448,772	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 10% over baseline of 27,100 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $450,077	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 15% over baseline of 27,100 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $371,802
Year 2 Estimated Total DSRIP: $411,360	Year 3 Estimated Total DSRIP: $448,772	Year 4 Estimated Total DSRIP: $450,077	Year 5 Estimated Total DSRIP: $371,802
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,682,012***			

Project Option: 1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.
Unique Project ID Number: 137921608.1.1 (Pass 1)
Performing Provider Name/TPI: Community Healthcore 137921608

Project Abstract:

Provider: Community Healthcore is a local community mental health center and the local mental health authority with over 400 employees. The center serves nine (9) counties in RHP1 for mental health and is the gateway for individuals in that catchment area that enter the state psychiatric hospital. The center also serves 23 counties with addiction recovery services, both in-patient and out-patient.
Intervention(s): Community Healthcore will operate a Regional Crisis Response Center **in Atlanta Texas** covering the northeast Texas area. This region will serve as short-term alternatives to inpatient psychiatric hospitalization. Included are 6 beds for stabilization (locked) and 12 beds for intensive residential services (unlocked). Course of care is examined, stabilize and redirect to the most appropriate, least restrictive treatment setting. Clinical services include emergency crisis screening, physician examination and psychiatric assessment (via telemedicine).
Need for the project: The Regional Crisis Response Center **in CHRISTUS St. Michael- Atlanta Hospital Atlanta, Texas** will serve to reduce the unnecessary use of CHRISTUS St. Michael and Wadley Medical Center's emergency departments (ED), as well as other local hospitals in this east and northeast Texas area. Crisis psychiatric care is NON-EXISTENT in the region; the closest state psychiatric inpatient setting is Rusk State Hospital, which is up to 200 miles away and there is an over-whelming need for crisis care among indigent adults with SMI, the absence of which is hindering the delivery of emergency services at all regional hospitals. A Regional Crisis Response Center will address the psychiatric crisis more rapidly, efficiently and durably. The status quo also jeopardizes the health of thousands of medically compromised patients who are unable to access timely care because of perpetual ED backlogs. The Regional Crisis Response Center will ease the load on the EDs, increase resource availability in an underserved region, and improve health outcomes for the target AND general patient populations. EDs are the only regional safety net for both children and adults with SMI who are in crisis but they are not equipped to provide lasting crisis abatement. Most regional hospitals do not have psychiatrists on staff and private practice psychiatrists do not seek staff privileges there because of the burden of taking ED calls. The status quo inadvertently contributes to the revolving door of symptom acuity and decompensation. The availability of the Longview Regional Crisis Response Center, an easily accessible location will enable patients to receive optimal care, achieving more lasting stability. It also will help law enforcement remain active in the field maintaining public safety rather than providing ED safety and continuous transport services to Rusk State Hospital.
Target population: The target population for the project will consist of the adults (18 years of age or older) with a serious mental illness (SMI) living in east Texas. Using data from the Annual Census of State and County Mental Health Hospitals (2005), we project: half will be age 25 to 44, three-quarters will be males, 95% will be insured or eligible for Medicaid, and 78% will be middle to lower middle income. Predominant diagnoses will be affective disorders and schizophrenia. (NOTE: Most if not all are expected to have life-limiting, untreated physical health problems, the identification and treatment of which will be advanced after crisis stabilization.)
Category 1 or 2 expected patient benefits: The project will serve a pro-rated 1/3 of the 1,000 adults (baseline) in partial year DY3. Core services to be provided include crisis stabilization, care transitioning and connection to continuity care. The project seeks to provide an additional 10% above the baseline in DY4 and 15% above the baseline in DY5.

Category 3 outcomes: IT-9.2 ED appropriate utilization *(Standalone measure)* Our goal is to reduce Emergency Department visits for target conditions, including Behavioral Health/Substance Abuse by 10% & 15% in DY4 and DY5 respectively.

Project Narrative

Brief Description/Delivery System Solution Proposed: Evidence based crisis intervention/stabilization and detox center with early intervention and intensive wrap- around services. Enabling strategies are to establish Regional Crisis Response Center (RCRC) managed by Community Healthcore, a Joint Commission accredited organization, the regional mental health authority, located within the region to enable accessibility. The RCRC will provide for involuntary and voluntary admissions. The RCRC will be equipped to identify psychiatric or substance abuse disorders, assess immediate and long-term treatment needs, alleviate symptoms and provide appropriate acute treatment, and will accept patients 24 hours per day, 7 days per week. Peer support staff will be available to build trust and hope in recovery. The level of care for each patient will change within 48 hours of entry, with most returning home to be followed by Assertive Community Treatment Teams and referral processes to outpatient services. On-site, 24-hour staffing will include RNs, LVNs, Licensed Counselors and Social Workers, Techs, Licensed Chemical Dependence Counselors and performance improvement manager. Telepsychiatry will be available around the clock.

Goal(s):
Project Goal: Expand the capacity of behavioral health services to improve quality care, and reduce fiscal impact to patients, hospitals, and community.

Community Healthcore and its partners have established three primary goals for improving crisis and continuity care in the region:

1. Improve the delivery and consistent integration of behavioral and physical health care through a seamless collaboration of public and private entities.
2. Fill resource gaps in crisis stabilization, care transitioning and accessible primary care, improving health outcomes and reducing costs associated with cyclical crises and inappropriate reliance on Emergency Departments (EDs).
3. Develop the infrastructure required for continuous communication, shared decision-making, continuity care between and among collaborators, and the prudent application of scarce primary, behavioral and tertiary care resources.

- **Starting Point/Baseline:**
  As a determinate of baseline activity Community Healthcore extrapolated from emergency department activity and compared with another regional crisis intervention model that closely resembles Community Healthcore's population, size and patient demographics. Based on the analytical review of the data described above Community Healthcore estimates than in Waiver Demonstration year three (DY3) 333 individuals will be served through the Crisis Response Center in CHRISTUS St. Michael-Atlanta Hospitas this partial year of operation and establishes the baseline of 1,000.

- **Rationale:**
  A regional planning group of stakeholders from six rural counties in east Texas and southwest Arkansas met to explore ways to solve a long-standing problem of overuse of limited Emergency Room resources by adults with serious mental illness. The development of Project Option 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system will meet this unique need for this area. All required core project components are applicable and will be met. This will meet

the specific community need CN.5 of the RHP1 Community Needs Assessment through this new initiative of Community Healthcore, the Performing Provider. The approach, which is affordable and easy to implement, includes establishment of a Regional Crisis Response Center designed to stabilize psychiatric patients and preserve scarce ER resources for medical patients. Adults served through the RCRC will be connected to continuing, integrated behavioral and physical health care to prevent or diminish future crises. Community Healthcore, the regional mental health authority, will ~~operate the Center, with support from three regional hospitals: CHRISTUS St. Michael in Texarkana, and Good Shepherd-Marshall and Good Shepherd-Longview~~ will subcontract with CHRISTUS St. Michael [and others] for physical premises [and any other services St. Michael would provide] at fair market value. Community-based, post-release continuity care will be provided by East Texas Border Health (ETBH), a Federally Qualified Health Center. These providers will detect and treat chronic diseases, slow the progression of diminished capacity, and connect all patients to prevention and wellness supports. A regional patient registry contributed to by all partners, will monitor compliance and outcomes and verify change in both domains. Workforce issues, i.e., limited clinical staff, will be lessened with the 24-hour availability of telepsychiatry. In a limited pilot of the proposed approach, funded by CHRISTUS St. Michael, reductions in hospital readmissions and per patient costs were verified. The project also will employ Community Health Workers (CHW) to provide care transitioning services and ease reentry from the RCRC to the community.

Challenges/Community Need and How the project is related to the regional goals:

When national prevalence data for SMI (6%) is applied to the regional population, we find that 29,622 adults in 9 counties can be expected to have SMI. The closest center is Rusk State Hospital, which is up to three hours away from one of our largest population center, and is constantly on divert status due to demand. This helps meet the Regional goals and community needs addressed in the Key Health Challenges of the Regional Community Needs Assessment and specifically addressing CN.5, Inappropriate emergency department utilization.

Expected Outcome:

By engaging individuals at the point of crisis without other medical need into emergency psychiatric care provides more rapid response, community retention, and more rapid recovery.

The project will meet CMS three-part aims as follows:

Improved care

- Result in expanded resources into additional underserved rural communities, improving the health profile of the region by rural residents receiving comprehensive mental health treatment in their own community where they have natural supports and are more likely to remain engaged.
- To increase Community Healthcore's ability to provide "the right care at the right time in the right setting" Community Healthcore will collaborate with local FQHC's to promote expansion of primary care resources into additional underserved rural communities, improving the health profile of the region.

Improved health outcomes

- All partners providing behavioral health care will have access to a regional intake and to enhance continuity, support medication reconciliation and avoid duplication of effort.

Lower costs

- The number of psychiatric patients seeking treatment from an ED will be reduced, lowering costs and increasing availability of scarce critical care resources for medical patients.
- Counties will experience significant cost savings and the availability of law enforcement for public safety uses will increase when deputy sheriffs do not have to make daily trips back and forth from remote areas of east Texas to the nearest state hospital.

- **Related Category 3 Outcome Measure(s):**
  IT-9.2 ED appropriate utilization *(Standalone measure)*
  - Reduce Emergency Department visits for target conditions
    - Behavioral Health/Substance Abuse

  - Data supporting why these outcomes are a priority for the RHP;
    - There is an over-whelming need for crisis care among adults with SMI, the absence of which is hindering the delivery of emergency services at all regional hospitals. For example, in 2011, the emergency rooms at CHRISTUS St. Michael, Wadley Regional and Good Shepherd-Longview Hospitals saw 3,292 cases that primarily involved a mental health crisis and 689 had to be transported to the state hospital. A Crisis Center could have better met their needs and more durably relieved their symptoms. There are rural communities across America dealing with the same or similar dynamics. Researchers have found that 20% of nonmetropolitan counties are without mental health services and 87% of federally designated Mental Health Professional Shortage Areas in the nation are in nonmetropolitan counties[47]. Inserting small crisis stabilization points in a rural, under-resourced region is an achievable and affordable step toward building a comprehensive mental health framework.
  - Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
    - There is growing recognition across health care systems that patient-centered, coordinated care is both efficient and effective. In the "Crossing the Quality Chasm" report, the Institute of Medicine (IOM) verified this assertion[48]. Similarly, A rural hospital in east Texas, CHRISTUS St. Michael, monitored this cycle over the past year and found that the average length of wait in the ER for a psychiatric patient was 9.2 hours. Their presenting problems tended to be psychiatric, with only 5% admitted for medical care. However, severely limited regional resources for inpatient psychiatric care (the closest state hospital is 100-200 miles away) mean ERs often have to hold these patients for days before a bed becomes available. The backlog created by the inappropriate use of ERs has negative ramifications for the larger community, especially medically compromised patients who have difficulty accessing care because the ERs are inundated with adults with SMI.
  - Explanation of how focusing on the outcomes will help improve the health of low-income populations.
    - In this region, the responsibility for continuity care often shifts to ill-equipped primary care providers. As part of the FQHC system, ETBH and TCC are optimally prepared and funded to fulfill these functions and coordinate care among all providers.

- **Relationship to other Projects:**
  This project will assist in **2.15.1 - Integrated Behavioral Health and Primary Care** by appropriate referrals from ED's and the Crisis Center keeping primary care settings able to appropriately **1.1.2 Expand Primary Care Capacity** without the extended time in dealing with individuals that need a stable location apart from the ED or primary care physician office. The RCRC will assist in **1.9.2 Improve Access to Specialty Care** through a specific location for emergency crisis response and thereby relieve local psychiatrists offices from community crisis response. The RCRC will also **2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a**

[47] Texas A&M University, Southwest Rural Health Research Center.
[48] Institute of Medicine, Committee on Quality of Health Care in America. CROSSING THE QUALITY CHASM: A New Health System for the 21st Century. 2001

specified setting. It will support **2.13.1 - Jail Diversion Expansion** by providing early intervention and appropriate referrals to the criminal justice system. It could further support **2.9.1- Patient Care Navigation Services** by assisting in care navigation support for frequent ED users. This would no doubt aid in **2.4 Redesign to Improve Patient Experience.**

- **Relationship to Other Performing Providers' Projects in the RHP:**
  - University Of Texas Health Science Center-Tyler is proposing a similar project that will be addressing issues in the southern region.
  - Andrews Center
  - Palestine Regional Medical Center

- **Required core project components:**
  - Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs).

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  - 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.

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  - Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings).

In an area where everybody knows your name, stigma is likely to be another major barrier to care, followed by geographic isolation and one of the highest uninsured populations in the country. Together, these factors have produced a subset of rural adults with severe mental illness (SMI) who

experience perpetual cycles of stability - decompensation - hospitalization or incarceration - back to stability. Each time the cycle repeats, the individual is likely to return to a state of wellness that is below where they started the last time, progressively diminishing capacity for self-care across domains.

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Community Healthcore and its partners will fill resource gaps in crisis stabilization, care transitioning and accessible primary care, improving health outcomes and reducing costs associated with cyclical crises and inappropriate reliance on EDs. At the Regional Crisis Response Center (RCRC) law enforcement and judges will be able to commit patients to the locked units. Voluntary admission also will be possible. Admission to the unlocked units will be voluntarily. The RCRC will be equipped to identify psychiatric or substance abuse disorders, assess immediate and long-term treatment needs, alleviate symptoms and provide appropriate acute treatment. The Centers will accept patients 24 hours per day, 7 days per week. Peer support staff will be available to build trust and hope in recovery. The level of care for each patient will change within 48 hours of entry, with most returning home. The RCRC will feature semi-private rooms and three meals per day. On-site, 24-hour staffing will include RNs, LVNs, Licensed Counselors and Social Workers, Aides and Licensed Chemical Dependence Counselors. Telepsychiatry will be available around the clock. A Community Health Worker (CHW) will provide care transitioning by meeting with all RCRC patients, with the introduction often made by trusted peer support staff. The CHW will assess the individual's need for assistance – medication management, case management, risk factors for further crises or disease escalation, continuity care for chronic conditions (diabetes, heart, hepatic, respiratory disease) – and complete an in-home health and wellness check (physical and behavioral) within five days of discharge. Consistent connection to integrated behavioral health and primary care is projected to reduce ED visits.

- 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.

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  RCRC would participate in learning collaborative if similar projects are available. A "lessons learned" action will be put in place. A plan for Rapid Cycle Change and development of a Team to collect data, develop a "college of lessons learned" for use in continuous quality improvement will be implemented. ~~Date TBD~~ within six (6) months of beginning the project.

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Unique Identifier	RHP PP Ref Number	Project Components	Project Title
137921608.1.1	1.13.1	1.13.1.a.b.c.d.e	Regional Crisis Response Center
Community Healthcore			TPI: 137921608
Related Category 3 Outcome Measure(s): 137921608.3.1	~~[unique Category 3 IT identifier(s)]~~ 3.IT-9.2	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ ED appropriate utilization (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestones **Milestone 1** P-1 Milestone: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. Metric 1 P-1.1 Number of meetings and participants. a. Data Source: Attendance lists Milestone 1 Estimated Incentive Payment (maximum amount): ~~$742,378~~ $762,724 **Milestone 2** P-2. Conduct mapping and gap analysis of current crisis system. **Metric 2** P-2.1 Metric: Produce a written analysis of community needs for crisis services. **Data Source:** Written plan Milestone 2 Estimated Incentive Payment (maximum amount): ~~$742,378~~ $762,724 **Milestone 3:** P-3 Milestone: Develop implementation plans for needed crisis	Process Milestones **Milestone 5** P-5 Milestone: Develop administration of operational protocols and clinical guidelines for crisis services. Metric 5 P-5.1. Completion of policies and procedures. **Data Source**: Internal policy and procedures documents and operations manual. Milestone 5 Estimated Incentive Payment (maximum amount): $1,040,446 **Milestone 6** P-6 Milestone: Evaluate and continuously improve crisis services Metric 6 P-6.1. Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source**: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)	Improvement Milestones **Milestone 8** I-11. Milestone: Costs avoided by using lower cost crisis alternative settings Metric 8 I-11.1. Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings such as ER, jail, hospitalization. ~~a. Numerator: Cost of services for individuals using the crisis alternative settings.~~ ~~b. Denominator: Total cost for crisis care to individuals in the regional partnership study area.~~ **Goal**: Decrease the cost of the use of the ED, jail, hospitalization by 15% in DY4. **Data Source**: Patients seen in Crisis alternative: document reviews; patient admission rosters, PDSA document. Claims, encounters and service event data from ER, forensic records, communality mental health uniform assessment data Milestone 8 Estimated Incentive Payment (maximum amount): $1,711,257 **Milestone 9** I-12. Milestone: Utilization of appropriate crisis alternatives	Improvement Milestones **Milestone 10** I-11. Milestone: Costs avoided by using lower cost crisis alternative settings Metric 10 I-11.1. Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings such as ER, jail, hospitalization. ~~a. Numerator: Cost of services for individuals using the crisis alternative settings.~~ ~~b. Denominator: Total cost for crisis care to individuals in the regional partnership study area.~~ **Goal**: Decrease the cost of the use of the ED, jail, hospitalization by 30% in DY5. **Data Source**: Patients seen in Crisis alternative: document reviews; patient admission rosters, PDSA document. Claims, encounters and service event data from ER, forensic records, communality mental health uniform assessment data Milestone 10 Estimated Incentive Payment (maximum amount): $1,656,226 **Milestone 11** I-12. Milestone: Utilization of appropriate crisis alternatives

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Related Category 3 Outcome Measure(s): 137921608.3.1	~~[unique Category 3 IT identifier(s)]~~ 3.IT-9.2	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ ED appropriate utilization (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
services. Metric 3 P-3.1 Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. **Data Source**: Written plan Milestone 4 Estimated Incentive Payment (maximum amount): ~~$783,072~~ $762,724 **Milestone 4** P-4 Milestone: Hire and train staff to implement identified crisis stabilization services. Metric 4 P-4.1 Number of staff hired and trained. a. Staff rosters and training records b. **Data Source:** Training curricula Milestone 4 Estimated Incentive Payment (maximum amount): ~~$783,072~~ $762,724	Milestone 6 Estimated Incentive Payment (maximum amount): $1,040,446 Improvement Milestones **Milestone 7** I-12. Milestone: Utilization of appropriate crisis alternatives Metric 7 -12.1 10% increase in utilization of appropriate crisis alternatives. ~~a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives~~ ~~b. Denominator: Number of people receiving community behavioral health services in RHP project sites.~~ This would be measured at specified time intervals throughout the project to determine if there was a decrease. c. Data source: Claims, encounter, and clinical record data. Rationale: see project goals. Milestone 7 Estimated Incentive Payment (maximum amount): $1,040,446	Metric 9 I-12.1 ~~10%~~ 12% increase in utilization of appropriate crisis alternatives. ~~a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives~~ ~~b. Denominator: Number of people receiving community behavioral health services in RHP project sites.~~ This would be measured at specified time intervals throughout the project to determine if there was a decrease. **Data source**: Claims, encounter, and clinical record data. **Rationale**: see project goals. Milestone 9 Estimated Incentive Payment (maximum amount): $1,711,257	Metric 11 I-12.1 15% increase in utilization of appropriate crisis alternatives. ~~a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives~~ ~~b. Denominator: Number of people receiving community behavioral health services in RHP project sites.~~ This would be measured at specified time intervals throughout the project to determine if there was a decrease. **Data source**: Claims, encounter, and clinical record data. **Rationale**: see project goals. Milestone 11 Estimated Incentive Payment (maximum amount): $1,656,217
Year 2 Estimated Milestone Bundle Amount:$3,050,899	Year 3 Estimated Milestone Bundle Amount: $3,121,337	Year 4 Estimated Milestone Bundle Amount: $3,422,505	Year 5 Estimated Milestone Bundle Amount: $3,312,442

Unique Identifier	**RHP PP Ref Number**	**Project Components**	**Project Title**	
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Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $12,907,183				

Project Option: 1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.
Unique Project ID Number: 137921608.1.2 (Pass 1)
Performing Provider Name/TPI: Community Healthcore 137921608

Project Abstract:

Provider: Community Healthcore is a local community mental health center and the local mental health authority with over 400 employees. The center serves nine (9) counties in RHP1 for mental health and is the gateway for individuals in that catchment area that enter the state psychiatric hospital. The center also serves 23 counties with addiction recovery services, both in-patient and out-patient.

Intervention(s): Community Healthcore will operate a Regional Crisis Response Center in the **Longview/Gregg County** area serving as short-term alternatives to inpatient psychiatric hospitalization. Included are 6 beds for stabilization (locked) and 12 beds for intensive residential services (unlocked). Course of care is examined, stabilize and redirect to the most appropriate, least restrictive treatment setting. Clinical services include emergency crisis screening, physician examination and psychiatric assessment (via telemedicine).

Need for the project: The Regional Crisis Response Center in the **Longview Good Shepherd Medical Center Hospital unit at Allegiance /Gregg County** will serve to reduce the unnecessary use of Good Shepherd Medical Center's (GMSC) emergency department (ED), as well as other local hospitals. GSMC's ED serves some 100,000 patients a year. This in effects places a Dallas or Houston size problem in this rural area. There is an over-whelming need for crisis care among indigent adults with SMI, the absence of which is hindering the delivery of emergency services at all regional hospitals. A Regional Crisis Response Center will address the psychiatric crisis more rapidly, efficiently and durably. The status quo also jeopardizes the health of thousands of medically compromised patients who are unable to access timely care because of perpetual ED backlogs. The Regional Crisis Response Center will ease the load on the EDs, increase resource availability in an underserved region, and improve health outcomes for the target AND general patient populations. EDs are the only regional safety net for both children and adults with SMI who are in crisis but they are not equipped to provide lasting crisis abatement. Most regional hospitals do not have psychiatrists on staff and private practice psychiatrists do not seek staff privileges there because of the burden of taking ED calls. The status quo inadvertently contributes to the revolving door of symptom acuity and decompensation. The availability of the Longview Regional Crisis Response Center, an easily accessible location will enable patients to receive optimal care, achieving more lasting stability. It also will help law enforcement remain active in the field maintaining public safety rather than providing ED safety and continuous transport services to Rusk State Hospital.

Target population: The target population for the project will consist of the adults (18 years of age or older) with a serious mental illness (SMI) living in east Texas. Using data from the Annual Census of State and County Mental Health Hospitals (2005), we project: half will be age 25 to 44, three-quarters will be males, 95% will be insured or eligible for Medicaid, and 78% will be middle to lower middle income. Predominant diagnoses will be affective disorders and schizophrenia. (NOTE: Most if not all are expected to have life-limiting, untreated physical health problems, the identification and treatment of which will be advanced after crisis stabilization.)

Category 1 or 2 expected patient benefits: The project will serve a pro-rated 1/3 of the 934 adults (baseline) in partial year DY3. Core services to be provided include crisis stabilization, care transitioning and connection to continuity care. The project seeks to provide an additional 10% above the baseline in DY4 and 15% above the baseline in DY5.

Category 3 outcomes: IT-9.2 ED appropriate utilization *(Standalone measure)* Our goal is to reduce Emergency Department visits for target conditions, including Behavioral Health/Substance Abuse by 10% & 15% in DY4 and DY5 respectively.

Project Narrative

Brief Description/Delivery System Solution Proposed: This project contemplates the development and implementation of an evidence based crisis intervention/stabilization and detox center with early intervention and intensive wrap around services. Enabling strategies are to establish Regional Crisis Response Center (RCRC) managed by Community Healthcore, the regional mental health authority, located within the region to enable accessibility. The RCRC will provide for involuntary and voluntary admissions. The RCRC will be equipped to identify psychiatric or substance abuse disorders, assess immediate and long-term treatment needs, alleviate symptoms and provide appropriate acute treatment, and will accept patients 24 hours per day, 7 days per week. Peer support staff will be available to build trust and hope in recovery. The level of care for each patient will be accessed during the 48 hours of entry, with most returning home to be followed by Assertive Community Treatment Teams and referral processes to outpatient services. On-site, 24-hour staffing will include RNs, LVNs, Licensed Counselors and Social Workers, Techs, Licensed Chemical Dependence Counselors and performance improvement manager. Telepsychiatry will be available around the clock.

Goal(s):
Project Goal: Expand the capacity of behavioral health services to improve quality care, and reduce fiscal impact to patients, hospitals, and community.

Community Healthcore and its partners have established three primary goals for improving crisis and continuity care in the region:

4. Improve the delivery and consistent integration of behavioral and physical health care through a seamless collaboration of public and private entities.
5. Fill resource gaps in crisis stabilization, care transitioning and accessible primary care, improving health outcomes and reducing costs associated with cyclical crises and inappropriate reliance on Emergency Departments (EDs).
6. Develop the infrastructure required for continuous communication, shared decision-making, continuity care between and among collaborators, and the prudent application of scarce primary, behavioral and tertiary care resources.

- **Starting Point/Baseline:**

As a determinate of baseline activity Community Healthcore extrapolated from emergency department activity and compared with another regional crisis intervention model that closely resembles Community Healthcore's population, size and patient demographics. Based on the analytical review of the data described above Community Healthcore estimates than in Waiver Demonstration year three (DY3) 311 individuals will be served through the Crisis Response Center in this partial year operation and establishes the baseline of 934.

- **Rationale:**

A regional planning group of stakeholders from six rural counties in east Texas and southwest Arkansas met to explore ways to solve a long-standing problem of overuse of limited Emergency Room resources by adults with serious mental illness. The development of Project Option 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system will meet this unique need for this area. All required core project components are applicable and will be met. This will meet

the specific community need CN.5 of the RHP1 Community Needs Assessment through this new initiative of Community Healthcore, the Performing Provider. The approach, which is affordable and easy to implement, includes establishment of a Regional Crisis Response Center designed to stabilize psychiatric patients and preserve scarce ER resources for medical patients. Adults served through the RCRC will be connected to continuing, integrated behavioral and physical health care to prevent or diminish future crises. Community Healthcore, the regional mental health authority, will operate the Center, with support from three regional hospitals: CHRISTUS St. Michael in Texarkana, and Good Shepherd-Marshall and Good Shepherd-Longview Community-based, post-release continuity care will be provided by East Texas Border Health (ETBH), a Federally Qualified Health Center. These providers will detect and treat chronic diseases, slow the progression of diminished capacity, and connect all patients to prevention and wellness supports. A regional patient registry contributed to by all partners, will monitor compliance and outcomes and verify change in both domains. Workforce issues, i.e., limited clinical staff, will be lessened with the 24-hour availability of telepsychiatry. In a limited pilot of the proposed approach, funded by CHRISTUS St. Michael, reductions in hospital readmissions and per patient costs were verified. The project also will employ Community Health Workers (CHW) to provide care transitioning services and ease reentry from the RCRC to the community.

Challenges/Community Need and How the project is related to the regional goals:

When national prevalence data for SMI (6%) is applied to the regional population, we find that 29,622 adults in 9 counties can be expected to have SMI. The closest center is Rusk State Hospital, which is up to three hours away from one of our largest population center, and is constantly on divert status due to demand. This helps meet the Regional goals and community needs addressed in the Key Health Challenges of the Regional Community Needs Assessment and specifically addressing CN.5, Inappropriate emergency department utilization.

Expected Outcome:

By engaging individuals at the point of crisis without other medical need into emergency psychiatric care provides more rapid response, community retention, and more rapid recovery.

The project will meet CMS three-part aims as follows:

Improved care

- Result in expanded resources into additional underserved rural communities, improving the health profile of the region by rural residents receiving comprehensive mental health treatment in their own community where they have natural supports and are more likely to remain engaged.
- To increase Community Healthcore's ability to provide "the right care at the right time in the right setting" Community Healthcore will collaborate with local FQHC's to promote expansion of primary care resources into additional underserved rural communities, improving the health profile of the region.

Improved health outcomes

- All partners providing behavioral health care will have access to a regional intake and to enhance continuity, support medication reconciliation and avoid duplication of effort.

Lower costs

- The number of psychiatric patients seeking treatment from an ED will be reduced, lowering costs and increasing availability of scarce critical care resources for medical patients.
- Counties will experience significant cost savings and the availability of law enforcement for public safety uses will increase when deputy sheriffs do not have to make daily trips back and forth from remote areas of east Texas to the nearest state hospital.

Related Category 3 Outcome Measure(s):

IT-9.2 ED appropriate utilization *(Standalone measure)*

- Reduce Emergency Department visits for target conditions
    - Behavioral Health/Substance Abuse

a. Data supporting why these outcomes are a priority for the RHP;
    i. There is an over-whelming need for crisis care among adults with SMI, the absence of which is hindering the delivery of emergency services at all regional hospitals. For example, in 2011, the emergency rooms at CHRISTUS St. Michael, Wadley Regional and Good Shepherd-Longview Hospitals saw 3,292 cases that primarily involved a mental health crisis and 689 had to be transported to the state hospital. A Crisis Center could have better met their needs and more durably relieved their symptoms. There are rural communities across America dealing with the same or similar dynamics. Researchers have found that 20% of nonmetropolitan counties are without mental health services and 87% of federally designated Mental Health Professional Shortage Areas in the nation are in nonmetropolitan counties[49]. Inserting small crisis stabilization points in a rural, under-resourced region is an achievable and affordable step toward building a comprehensive mental health framework.
b. Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
    i. There is growing recognition across health care systems that patient-centered, coordinated care is both efficient and effective. In the "Crossing the Quality Chasm" report, the Institute of Medicine (IOM) verified this assertion[50]. Similarly, A rural hospital in east Texas, CHRISTUS St. Michael, monitored this cycle over the past year and found that the average length of wait in the ER for a psychiatric patient was 9.2 hours. Their presenting problems tended to be psychiatric, with only 5% admitted for medical care. However, severely limited regional resources for inpatient psychiatric care (the closest state hospital is 100-200 miles away) mean ERs often have to hold these patients for days before a bed becomes available. The backlog created by the inappropriate use of ERs has negative ramifications for the larger community, especially medically compromised patients who have difficulty accessing care because the ERs are inundated with adults with SMI.
c. Explanation of how focusing on the outcomes will help improve the health of low-income populations.
    i. In this region, the responsibility for continuity care often shifts to ill-equipped primary care providers. As part of the FQHC system, ETBH and TCC are optimally prepared and funded to fulfill these functions and coordinate care among all providers.

- **Relationship to other Projects:**
  This project will assist in **2.15.1 - Integrated Behavioral Health and Primary Care** by appropriate referrals from ED's and the Crisis Center keeping primary care settings able to appropriately **1.1.2 Expand Primary Care Capacity** without the extended time in dealing with individuals that need a stable location apart from the ED or primary care physician office. The RCRC will assist in **1.9.2 Improve Access to Specialty Care** through a specific location for emergency crisis response and thereby relieve local psychiatrists offices from community crisis response. The RCRC will also **2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting.** It will support **2.13.1 - Jail Diversion Expansion** by providing early intervention and

[49] Texas A&M University, Southwest Rural Health Research Center.
[50] Institute of Medicine, Committee on Quality of Health Care in America. CROSSING THE QUALITY CHASM: A New Health System for the 21st Century**.** 2001

appropriate referrals to the criminal justice system. It could further support **2.9.1- Patient Care Navigation Services** by assisting in care navigation support for frequent ED users. This would no doubt aid in **2.4 Redesign to Improve Patient Experience.**

- **Relationship to Other Performing Providers' Projects in the RHP:**
    a. University Of Texas Health Science Center-Tyler is proposing a similar project that will be addressing issues in the southern region.
    b. Andrews Center
    c. Palestine Regional Medical Center

- **Required core project components:**
    - Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs).

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community. Transportation costs for the counties will be reduced and will free law enforcement to return to work “on the streets” for safety issues.

~~[Unique Category 1 Project Identifier, e.g. Project [TPI].1.1]~~ 137921608.1.2	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 1.13.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 1.13.1.A.B.C.D.E	Regional Crisis Response Center
Community Healthcore			137921608
Related Category 3 Outcome Measure(s): 137921608.3.2	~~[unique Category 3 IT identifier(s)]~~ 3.IT-9.2	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ ED appropriate utilization (Standalone measure)

Process Milestones **Milestone 1** P-1 Milestone: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. Metric 1 P-1.1 Number of meetings and participants. **Data Source**: Attendance lists Milestone 1 Estimated Incentive Payment (maximum amount): ~~$811,230~~ $831,577 **Milestone 2** P-2. Conduct mapping and gap analysis of current crisis system. Metric 2 P-2.1 Produce a written analysis of community needs for crisis services. **Data Source:** Written plan	Process Milestones **Milestone 5** P-5 Milestone: Develop administration of operational protocols and clinical guidelines for crisis services. Metric 5 P-5.1 Completion of policies and procedures. **Data Source**: Internal policy and procedures documents and operations manual. Milestone 5 Estimated Incentive Payment (maximum amount): $877,145 **Milestone 6** P-6 Milestone: Evaluate and continuously improve crisis services Metric 6 P-6.1 Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source**: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous	Improvement Milestones **Milestone 8** I-11. Milestone: Costs avoided by using lower cost crisis alternative settings Metric 8 I-11.1 Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings such as ER, jail, hospitalization. **Goal**: Decrease the cost of the use of the ED, jail, hospitalization by 30% in DY4. **Data Source**: Patients seen in Crisis alternative: document reviews; patient admission rosters, PDSA document. Claims, encounters and service event data from ER, forensic records, communality mental health uniform assessment data Milestone 8 Estimated Incentive Payment (maximum amount): $1,466,828 **Milestone 9** I-12. Milestone: Utilization of	Improvement Milestones **Milestone 10** I-11. Milestone: Costs avoided by using lower cost crisis alternative settings Metric 10 I-11.1 Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings such as ER, jail, hospitalization. **Goal**: Decrease the cost of the use of the ED, jail, hospitalization by 30% in DY5 **Data Source**: Patients seen in Crisis alternative: document reviews; patient admission rosters, PDSA document. Claims, encounters and service event data from ER, forensic records, communality mental health uniform assessment data Milestone 10 Estimated Incentive Payment (maximum amount): $1,522,708 **Milestone 11** I-12. Milestone: Utilization of

~~[Unique Category 1 Project Identifier, e.g. Project [TPI].1.1]~~ 137921608.1.2	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 1.13.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 1.13.1.A.B.C.D.E	Regional Crisis Response Center
Community Healthcore			137921608
Related Category 3 Outcome Measure(s): 137921608.3.2	~~[unique Category 3 IT identifier(s)]~~ 3.IT-9.2	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ ED appropriate utilization (Standalone measure)

Milestone 2 Estimated Incentive Payment (maximum amount): ~~$811,230~~ $831,577 **Milestone 3**: P-3 Milestone: Develop implementation plans for needed crisis services. Metric 3 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. a. Data Source: Written plan Milestone 4 Estimated Incentive Payment (maximum amount): ~~$851,924~~ $831,577 **Milestone 4** P-4 Milestone: Hire and train staff to implement identified crisis stabilization services. **Metric 4** P-4.1. Metric: Number of staff hired	quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 6 Estimated Incentive Payment (maximum amount): $877,145 Improvement Milestones Milestone 7 I-12. Milestone: Utilization of appropriate crisis alternatives **Metric 7** Metric: 10% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the project to determine if there was a decrease. c. Data source: Claims, encounter, and clinical record data. Rationale: see project goals.	appropriate crisis alternatives Metric 9 I-12.1 Metric: ~~10%~~ 12% increase in utilization of appropriate crisis alternatives. **Data source**: Claims, encounter, and clinical record data. **Rationale**: see project goals. Milestone 9 Estimated Incentive Payment (maximum amount): $1,466,819	appropriate crisis alternatives Metric 11 I-12.1 Metric: 15% increase in utilization of appropriate crisis alternatives. **Data source**: Claims, encounter, and clinical record data. **Rationale**: see project goals. Milestone 11 Estimated Incentive Payment (maximum amount): $1,522,699

~~[Unique Category 1 Project Identifier, e.g. Project [TPI].1.1]~~ 137921608.1.2	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 1.13.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 1.13.1.A.B.C.D.E	Regional Crisis Response Center	
Community Healthcore				137921608
Related Category 3 Outcome Measure(s): 137921608.3.2	~~[unique Category 3 IT identifier(s)]~~ 3.IT-9.2	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ ED appropriate utilization (Standalone measure)	
[redacted]				
and trained. a. Staff rosters and training records b. Data Source: Training curricula Milestone 4 Estimated Incentive Payment (maximum amount): ~~$851,924~~ $831,577	Milestone 7 Estimated Incentive Payment (maximum amount): $877,145			
Year 2 Estimated Milestone Bundle Amount: $3,326,308	Year 3 Estimated Milestone Bundle Amount: $2,631,436	Year 4 Estimated Milestone Bundle Amount: $2,933,647	Year 5 Estimated Milestone Bundle Amount: $3,045,406	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $11,936,797				

Project Option: 1.9.2 Improve access to specialty care
Unique Project ID Number: 137921608.1.3 (Pass 2)
Performing Provider Name/TPI: Community Healthcore 137921608

Project Abstract

Provider: Community Healthcore is a local community mental health center and the local mental health authority with over 400 employees. The center serves nine (9) counties in RHP1 for mental health and is the gateway for individuals in that catchment area that enter the state psychiatric hospital. The center also serves 23 counties with addiction recovery services, both in-patient and out-patient.

Intervention(s): Community Healthcore will operate an ambulatory detoxification clinic in a non-residential setting co-located with the University of Texas Health Science Center-Tyler primary care clinic. The program will provide a safe withdrawal from the drug(s) of dependence and enable the individual to become drug free through a medical model program. Continuity of services will facilitate a transitions plan from detoxification to community support services with the development and documentation of a referral plan appropriate for each individual involving outpatient treatment with structured programming. Development of a service plan to address the needs of special populations will include: perinatal, elderly, mentally ill, sedative/hypnotic addicts, and patients with special medical needs, HIV, STD, Hepatitis C, and TB, for example. Interventions will include minimum standards for medical clearance and medical exclusion before admission, as well as standards for withdrawal management and reliable access to medical services through the UTHSC-T Primary Care Clinic.

Need for the project: In underserved areas, as the target location, individuals needing assistance with detoxification from substances and for patients with mild-to-moderate alcohol withdrawal syndrome, characterized by symptoms such as hand tremor, perspiration, heart palpitation, restlessness, loss of appetite, nausea, and vomiting, outpatient detoxification is as safe and effective as inpatient detoxification but is much less expensive and less time consuming. In addition, patients who enroll in long-term outpatient rehabilitation treatment following detoxification can continue to function relatively normally and maintain employment as well as family and social relationships. Compared with inpatients, those patients in outpatient treatment retain greater freedom, continue to work and maintain day-to-day activities with fewer disruptions, and incur fewer treatment costs.

Target population: The target population for the project will consist of the adults (18 years of age or older) assessed appropriate for ambulatory detoxification services that can be clinically justified. Identification of alcohol and illicit drugs used with need for detoxification to perform in their daily lives will be the primary population. There is no withdrawal syndrome associated with either marijuana or hallucinogens, and some "designer drugs". Most patients can be detoxified from alcohol in 3-5 days and opiate withdrawal varies, for heroin or morphine, 5-7 days. Other Narcotic withdrawal may require Narcotic Replacement Therapy under medical supervision. Stimulant withdrawal, 2-4 days Sedatives & Benzodiazepines varies. Clients needing longer stabilization periods will be assisted by partner agencies that provide in-patient detoxification services. Additional stays in detox for stabilization purposes will be approved on a case-by-case basis.

Category 1 or 2 expected patient benefits: The project will serve 259 adults (baseline) in DY3. Core services to be provided include ambulatory detoxification, care transitioning and connection to community

based cognitive behavioral therapy services through continuity of care. The project seeks to provide an additional 10% above the baseline in DY4 and 15% above the baseline in DY5.

Category 3 outcomes: IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure) Our* goal is to reduce the number of readmissions to inpatient or ambulatory detoxification services for target conditions by 10% & 15% in DY4 and DY5 respectively from the baseline.

Project Narrative

Brief Description/Delivery System Solution Proposed: This project will develop and implement an evidence based ambulatory detoxification program supported by the American Society of Addiction Medicine (ASAM). Ambulatory detoxification is typically indicated when there is minimal risk of severe withdrawal and co-occurring mental health and/or medical conditions – if present – can be safely managed in an ambulatory setting. Detoxification services are designed to administer to the severity of the patient's level of intoxication and achieve a safe and supportive withdrawal from alcohol and/or other drugs. Assessment of acute intoxication and withdrawal risks, bio-medical conditions and complications and cognitive, behavioral and emotional situations will help determine the patient's readiness for services. Detoxification refers not only to the attenuation of the physical and psychological features of withdrawal syndromes, but also to the process of interrupting the momentum of compulsive use. The program will be comprised of services that are provided in an outpatient setting for the purpose of completing a medically safe withdrawal from substances. The program will effectively facilitate the participant's transition into ongoing out-patient services, including referrals to local mental health services, designed to treat the individual's assessed level of illness severity and to achieve permanent changes in substance using behavior. Needs for psychiatric and medical services are addressed through consultation or referral arrangements.

Goal(s):

Project Goal: To increase the capacity for specialty care services for patients needing ambulatory detoxification and the availability of targeted specialty care providers to better accommodate the high demand for these patients. By assisting participants in the detoxification program to address acute withdrawal symptoms and achieve abstinence from alcohol and/or drugs it will serve as the first step to achieving recovery from chemical dependency and to successfully engage clients in ongoing treatment services and referrals after successful completion. A period of psychological readjustment is required after detoxification and prepares patients for the next step in continuing treatment.

PROJECT COMPONENT(S) 1.9.2

Improve access to specialty care

a. Increase service availability with extended hours

Community Healthcore, in partnership with UTHSC-Tyler and the Andrews Center, will expand ambulatory detox access to enable patients to receive care in a clinic setting that will have extended evening hours to accommodate individuals that are unable to seek help during normal working hours and reduce wait times. Community Healthcore's goal is to provide the best patient care for individuals needing detoxification services but unable to access inpatient care.

b. Increase number of specialty clinic locations

There are no ambulatory detoxification services in the northern Tyler area for individuals with low or no income. Partnering with UTHSC-Tyler, Community Healthcore will provide an additional location for individuals needing medical detoxification services in this low income area.

c. Implement transparent, standardized referrals across the system

Standardized referral guidelines will be developed and used. These will track time and appropriateness of referrals to ensure timeliness of admission and reduce the number of patients inappropriately referred.

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

Participation in a learning collaborative with University Of Texas Health Science Center-Tyler in a "lessons learned" initiative will further benefit patients identifying potential difficulties in referrals with specialty populations. A plan for Rapid Cycle Change and development of a team to collect data, develop a "college of lessons learned" for use in continuous quality improvement will be implemented.

- **Starting Point/Baseline:**

As a determinate of baseline activity and based on the analytical review of the data Community Healthcore estimates than in Waiver Demonstration year three (DY3) 250 individuals will be served through the Ambulatory Detoxification Clinic.

- **Rationale:**

A local planning group of stakeholders from University Of Texas Health Science Center-Tyler, Andrews Center Local Mental Health Authority and Community Healthcore met to explore ways to solve a long-standing problem of an underserved area of Tyler, Texas for primary care, mental health services and substance abuse needs. The individuals that will be targeted in this project typically overuse Emergency Department resources for both primary care and mental health/substance abuse treatment. This will meet the specific community need CN.1 Insufficient access to primary and specialty health care services; CN.2 Insufficient access to mental and behavioral health services; CN.4 High costs due to potentially preventable hospitalizations; and CN.5 Inappropriate emergency department utilization of the RHP1 Community Needs Assessment. Community Healthcore, University of Texas Health Science Center-Tyler and the Andrews Center will collaborate to establish a co-located clinic in underserved areas, and will provide specialty care (ambulatory detoxification), primary care and mental health follow-up designed to treat patients that frequent emergency department for their primary and mental health/substance abuse care and preserve scarce ED resources for urgent and emergent medical patients.

Challenges/Community Need and How the project is related to the regional goals:

By engaging individuals in an ambulatory detoxification setting rather than inpatient the project will support CMS and the RHP1 regional goals of I**mproved care** for patients with mild-to-moderate need that is as safe and effective as inpatient detoxification increasing Community Healthcore's ability to provide "the right care at the right time in the right setting. **"Improved health outcomes** Community Healthcore will collaborate with the University of Texas Health Science Center-Tyler outpatient clinic to promote expansion of primary care resources into additional underserved rural communities, improving the health profile of the region.

All partners providing behavioral health care will have access to a regional intake and to enhance continuity, support medication reconciliation and avoid duplication of effort. And, **Lower costs** through outpatient versus inpatient settings and better engaging patient in transition care and reduce readmission rates to either inpatient or outpatient settings.

Expected Outcome:

Improve access to specialty care, ambulatory detoxification services, in an underserved area and increase the number of specialty clinic locations thereby reducing the risk associated with acute levels of intoxication including withdrawal symptoms/seizures. Address current physical illnesses, other than withdrawal that may complicate treatment and assess psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment. With regard to underserved areas, in collaboration with UTHSC-T develop residency training for the direct support of medical education. Residency programs are costly and there is a great need for extended residency rotation training.

Related Category 3 Outcome Measure(s):

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

Reduce the number of readmissions for patients 18 years and older within 30 day of discharge from initial admission and substance abuse is indicated at either the primary or secondary diagnosis.

- These outcomes are a priority for the RHP. The UTHSC-Tyler determined that there is an over-whelming need for treatment protocols that would help reduce costs, provide safe care and develop a wraparound transition plan to address readmissions. Individuals with a secondary diagnosis of behavioral health (mental health or substance abuse) are more likely to experience readmissions. Targeted individuals for outpatient (ambulatory) detoxification can reduce costs and protocols to identify these patients appears to lower admissions to in-patient settings and 30-day readmission rates for alcohol detoxification. (Stephens, John, Dancel, Ria, Kirsch, Jonathan, Liles, Allen, Gilchrist, Michael, Stepanek, Kelly; WHO NEEDS DETOX? A PROTOCOL FOR EVALUATION OF PATIENTS WITH ALCOHOL WITHDRAWAL [abstract]. Journal of Hospital Medicine 2012;7 Suppl 2 :174). Availability of ambulatory detoxification within underserved areas that often result in crisis care among adults with SMI will provide opportunity for keeping individuals in the community, lowering costs, improving care and health outcomes, the absence of which is hindering the delivery of emergency services at all regional hospitals. There are rural communities across America dealing with the same or similar dynamics. Researchers have found that 20% of nonmetropolitan counties are without mental health services and 87% of federally designated Mental Health Professional Shortage Areas in the nation are in nonmetropolitan counties[51]. Insertion of co-located disciplines in clinics in a rural, under-resourced region is an achievable and affordable step toward building a comprehensive primary care and mental health/substance abuse framework. By focusing on the outcomes it will help improve the health of low-income populations in this region. Without these alternatives the responsibility for continuity care often shifts to ill-equipped primary care providers. As part of the University of Texas Health Science Center-Tyler system this clinic will be optimally prepared and funded to fulfill these functions and coordinate care.

- **Relationship to other Projects:**

This project will assist in **2.15.1 - Integrated Behavioral Health and Primary Care** by appropriate referrals from ED's and the Crisis Center keeping primary care settings able to appropriately **1.1.2 Expand Primary Care Capacity** without the extended time in dealing with individuals that need detoxification services. The ambulatory detoxification clinic will also support **2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting.** It will support **2.13.1 - Jail Diversion Expansion** by providing early intervention and appropriate referrals that may keep individuals from entering the criminal justice system. It could further support **2.9.1- Patient Care Navigation Services** by assisting in care navigation support for frequent ED users. This will also provide a fundamental support in **2.4 Redesign to Improve Patient Experience.**

[51] Texas A&M University, Southwest Rural Health Research Center.

- **Relationship to Other Performing Providers' Projects in the RHP:**
    - University Of Texas Health Science Center-Tyler is proposing a similar project that will be addressing issues in the southern region.
    - Andrews Center

- **Plan for Learning Collaborative:**

Leadership and quality improvement staff will participate in a learning collaborative with University Of Texas Health Science Center-Tyler in a "lessons learned" initiative. A plan for Rapid Cycle Change and development of a team to collect data, develop a "college of lessons learned" for use in continuous quality improvement will be implemented ~~Date TBD~~ within six (6) months of beginning the project.

- **Project Valuation:**

The value of this project is based on cost savings from emergency department use, prolonged illnesses and loss of work in the community and inappropriate readmissions.

Methodology: For every individual seen in the specialty care setting versus non-emergent ED visits there is cost avoidance. Calculating savings of $150-$500 savings to the health care system through admission to specialty care treatment and the average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected The total valuation is calculated by summing health care costs, individual costs, and community costs.

Rationale: Specialty care visit outcome improvement targets are dependent on the target population served, but is believed that this will reduce ED use for specialty care needs, (e.g., recidivism , patients with more than three visits in a year), and current processes in place and being developed that navigate recidivist away from the emergency department.

~~[Unique Category 1 Project Identifier, e.g. Project [TPI].1.1]~~ 137921608.1.3	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 1.9.2	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 1.9.2.A.B.C.D.	Expand Specialty Care Capacity, Ambulatory Detox
Community Healthcore			137921608
Related Category 3 Outcome Measure(s): 137921608.3.3	~~[unique Category 3 IT identifier(s)]~~ 3.IT-3.8	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ Behavioral Health/Substance Abuse 30 day readmission rate (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestones **Milestone 1** P-1 Milestone: Conduct specialty care gap assessment based on community need Metric 1. P-1.1 Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). **Data Source**: Needs Assessment Milestone 1 Estimated Incentive Payment (maximum amount): $228,435 **Milestone 2** P-4. Milestone: Expand the ambulatory care medical specialties referral management department and related functions **Metric 2** P-4.1. Metric: Referral Management system utilization ~~Numerator: Number of unique referrals placed and tracked~~	Process Milestones **Milestone 3** P-11. Milestone: Launch/expand a specialty care clinic (e.g., ambulatory detoxification clinic) Metric 3 P-11.1 Metric: Establish/expand specialty care clinics Number of patients served by specialty care clinic **Data Source**: Documentation of new/expanded specialty care clinic Baseline/Goal: Establish ambulatory detox clinic that will see 259 adult patients in DY3. Milestone 3 Estimated Incentive Payment (maximum amount): $257,242 Improvement Milestones **Milestone 4** I-33. Milestone: Increase specialty care capacity using innovative project option. **Metric 4** I-33.1. Metric: Increase percentage of	Improvement Milestones **Milestone 5** I-33. Milestone: Increase specialty care capacity using innovative project option. Metric 5 I-33.1 Increase percentage of target population reached. **Data Source:** Documentation of target population reached, as designated in the project plan. (~~15%~~ 12% increase in utilization by target population to 290 in DY4.) Milestone 5 Estimated Incentive Payment (maximum amount): $561,617	Improvement Milestones **Milestone 6** I-33. Milestone: Increase specialty care capacity using innovative project option. Metric 6 I-33.1 Increase percentage of target population reached. **Data Source**: Documentation of target population reached, as designated in the project plan. (15% increase in utilization by target population to 333 in DY5.) Milestone 5 Estimated Incentive Payment (maximum amount): $546,247

~~[Unique Category 1 Project Identifier, e.g. Project [TPI].1.1]~~ 137921608.1.3	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 1.9.2	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 1.9.2.A.B.C.D.	Expand Specialty Care Capacity, Ambulatory Detox	
Community Healthcore				137921608
Related Category 3 Outcome Measure(s): 137921608.3.3	~~[unique Category 3 IT identifier(s)]~~ 3.IT-3.8	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ Behavioral Health/Substance Abuse 30 day readmission rate (Standalone measure)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
~~within the system during the reporting period. Denominator: Total number of referrals made to the specialty practice during the reporting period.~~ **Data Source**: Reports generated by the Referral Management system, EHR and other administrative reports as needed Milestone 2 Estimated Incentive Payment (maximum amount): $228,435	target population reached. **Data Source**: Documentation of target population reached, as designated in the project plan. Milestone 4 Estimated Incentive Payment (maximum amount): $257,242		
Year 2 Estimated Milestone Bundle Amount: $456,869	Year 3 Estimated Milestone Bundle Amount: $514,484	Year 4 Estimated Milestone Bundle Amount: $561,617	Year 5 Estimated Milestone Bundle Amount: $546,247
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,079,217			

Project Option: 1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
Unique Project ID Number: 138365512.1.1 (Pass 1)
Performing Provider Name/TPI: Andrews Center 138365512

Project Abstract

Provider Description: Andrews Center Behavioral Healthcare System is a non-profit, comprehensive mental health and mental retardation center. Services are provided in a five-county area of Northeast Texas (Smith, Wood, Rains, Van Zandt and Henderson) with an estimated population of 390,014.

Intervention: This project will implement a crisis intervention program consisting of a location where individuals in crisis could be brought for a period of 4 to 23 hours in order to allow for stabilization and planning for optimal placement.

Need for the Project: Behavioral health patients in crisis currently have very few options other than local hospital emergency rooms in which to receive care. This is especially true after business hours when EDs are truly the only option. The community needs assessment also cites insufficient access to behavioral care services (CN.2) and inappropriate emergency room utilization (CN.5).

Target Population: The target population is patients experiencing a behavioral health crisis that have limited access to behavioral health services and would otherwise seek care in the ED. We anticipate approximately 1400 potential crisis patients per year with a smaller subset of those (200+) being appropriate candidates for the proposed crisis stabilization alternatives. This population has a Medicaid and indigent population of at least 55%.

Category 1 or 2 Expected Patient Benefits: The crisis intervention project will increase the usage of appropriate crisis alternatives over an estimated baseline of 14.2% (200 usages out of a potential 1400 crisis calls). We will validate this baseline with actual data in DY3, and then seek to increase appropriate usage by 20% (240 total uses) in DY4 and 30% (260 total uses) in DY5. Patients will benefit from increased access to behavioral health services.

Category 3 Outcomes: The crisis intervention program will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients (IT-9.2). Andrews Center plans to decrease ED visits for patients receiving interventions through crisis stabilization services by 10% and 15% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: The goal of the crisis intervention program is to achieve stabilization of behavioral health patients who are in crisis at a central location or locations in the community. This program will seek to decrease admissions to state hospitals, state schools, and private psychiatric hospitals; minimize law enforcement time spent and reduce emergency room utilization. We estimate a baseline utilization percentage of crisis stabilization services to be 14.2% (200 individuals out of an estimated 1400 crisis calls) but will gather data in DY3 to validate or adjust this baseline. The goal of the Crisis Stabilization program is to realize an increase in the use of appropriate crisis alternatives and we plan to increase utilization by 20% over baseline in DY4 and 30% over baseline in DY5. This represents an additional 40 usages in DY4 (240 total) and an additional 60 usages in (260 total) in DY5.

Consistent with the overarching goal and vision of RHP 1, Andrews Center is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of Andrews Center. Northeast Texas is an area where patients face many challenges in accessing primary, specialty, and behavioral health care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, Andrews Center is proposing to develop and implement crisis stabilization services to address the identified gaps in the current community crisis system. Expanding behavioral health care access with crisis services meets several community needs outlined by RHP 1, including: insufficient access to behavioral care services (CN.2), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

The Andrews Center will work with community partners to develop a crisis intervention program that meets the goals above. Though the details of such a program will be determined in the initial planning year of the DSRIP project, it is envisioned that a crisis intervention program will consist of a location or locations where individuals in crisis could be brought for a period of 4 to 23 hours in order to allow for stabilization and planning for optimal placement. Such a location could consist of 8-10 ‘chairs’ and be staffed by a number of psychiatric care professionals (perhaps overseen by a psychiatrist), who could both stabilize patients and develop the most appropriate care plan. More specifically, detailed planning will also meet the following core project components:

- Identify and collaborate with community partners (hospitals, law enforcement, County Courts, etc.) to determine needs and areas of focus.

- Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.

- Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals.
- Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.
- 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.
- Determine staffing requirements for managing Mobile Crisis Incidents to stated population.

Patients in crisis currently have very few options other than local hospital emergency rooms in which to receive care. This is especially true after business hours when EDs are truly the only option. Once these patients arrive at the emergency room patients often find that:

- ED staff is not trained in to deal with Mental Health, substance abuse and suicide prevention issues.
- No immediate psychiatric intervention during crisis assessment
- Appointments to see a psychiatrist are sometimes weeks and months away
- No interpreter available for face to face evaluations in an area with a high Hispanic population
- Law enforcement is often required to stay with patients during their ER stay.

Moreover, emergency room discharge planning is often impeded by:

- No MH deputy on site in 3 of the 4 outpatient clinics for situations that warrant law enforcement intervention; sometimes no access to deputy in the Tyler clinic due to other obligations of the position
- Lack of designated staff that can physically accompany the patient from crisis episode to referral resources and appointments
- No form of transportation within and across county lines to referral resources (hospital, inpatient rehab, doctors' appointments, etc.). Law enforcement is not always available.

Starting Point/Baseline: As a new initiative for the Andrews Center, there is currently no baseline data for crisis center utilization; therefore, we plan to establish a baseline percentage

of utilization of crisis alternatives in DY 3. In order to plan for crisis utilization, we were able to look at historical data for our crisis hotline.

Andrews Center has a contract with AVAIL SOLUTIONS, INC. for hotline services. Data is kept on a monthly basis as to the number of calls received by this service and the number of Mobile Crisis Outreach Team (MCOT) activations. This data also captures the number of calls that originated from a hospital, law enforcement, or other entity (individuals, families, doctors' offices, etc.). The data has a breakdown of calls regarding adults vs. children; however, there is no breakdown at this time of the number of Individuals with Developmental Disabilities (IDD) consumers or those with language barriers. From this data, there appears to be an average of 350 total calls per month, of which a smaller number are actual crisis situations. Of those calls 33% originate from hospitals.

As summarized in the table below, we have predicted Andrews Center's estimated demand for crisis services.

Estimated Crisis Stabilization Demand Andrews Center	
Crisis Hotline Calls	1080
Non Hotline Crisis patients	320
Crisis Center Potential Need	1400
Crisis Patients Per Day	4
Crisis Patients In ED's	33%
ED Crisis Patients	462
Program DY5 Service Target	260
Law Enforcement Hours Per Pt	6
Potential LEO Manhour Savings	1560

Rationale: Because of the need for medical clearance, a lack of a safe place to perform evaluations after hours and a lack of an area crisis intervention/stabilization unit, the local ERs appear to be the most used safe arena for assessments (usually initiated by the consumer). Partnering with a hospital in the local area for crisis intervention/stabilization would alleviate many of these issues.

As noted in the Region 1 community needs assessment (CN.2 and CN.5), there is a shortage of behavioral health providers and services causing inappropriate ED utilization. Our crisis stabilization plan will strive to fill the shortage gap of behavioral health services. Due to a shortage of medical services, some crisis interventions appointments that could be provided as needed are lacking. If services could be provided on an intense outpatient basis, some of the state inpatient beds that are now being used for precautionary measures could be alleviated. Also, many patients are admitted to the medical hospital for lack of a viable outpatient plan or bed availability in a local private hospital or state hospital.

Related Category 3 Outcome Measures: According to the Texas Department of State Health Services, nearly 50% of 2008 hospitalizations in Texas had a secondary diagnosis of a mental health condition. A vast majority of these hospitalization initiated in the ED due to the shortage of crisis intervention services.

The crisis intervention program will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients (IT-9.2). The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in ED visit reduction. Andrews Center plans to decrease ED visits for patients receiving interventions through crisis stabilization services by 10% and 15% in demonstration years 4 and 5, respectively.

The previously stated project description and rationale further describes how implementing the crisis stabilization program will reduce emergency department visits for behavioral health/substance abuse patients.

Relationship to Other Projects: All three of Andrew Center's project plans work together to expand behavioral health services and to prevent potential admissions, readmissions, and ED visits. The first step is to intervene at the ED and appropriately send behavioral health patients to a Regional Crisis Response Centers. These crisis intervention and stabilization centers (751281410.1.1) will more efficiently serve behavioral health needs and get them specialized, cost effective care. Another intervention point is the criminal justice system through our jail diversion program (751281410.2.1). Similar to the crisis stabilization program, our community health workers and criminal justice system stakeholders will work together to keep behavioral health patients out of jail. After crisis stabilization and jail diversion, patients will be guided to the appropriate follow up care in our proposed physical-behavioral health integration program (2751281410.2.2). Patients will have access to our psychiatrists and primary care physicians, in order to meet their physical and behavioral health needs. In order to maintain the appropriate follow-up care, Andrews Center has a need to expand outpatient therapy services with 2 new licensed therapists (751281410.2.3).

Relationship to Other Performing Providers' Projects in the RHP: Andrews Center has ensured that all project plans meet the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of similar projects by Access and Community Healthcore in the RHP. Furthermore, we will participate in learning collaboratives to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: Andrews Center plans to participate in RHP-wide learning collaboratives with other providers with similar crisis intervention projects. Engaging in

learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: Studies have demonstrated the adverse effects of emergency department boarding of behavioral health patients—the most typical access point for crisis intervention patients. Excessive resource utilization, throughput, and financial impact of psychiatric patients awaiting inpatient placement places a burden on hospital EDs and negatively impacts appropriate care for the behavioral health population. The financial impact of psychiatric boarding accounts for a direct loss of $1,198 compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department $2,264 per patient. Lastly, psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers (additional patients) per psychiatric patient—decreasing financial revenue for the ED and costing the healthcare system more reimbursement dollars. In addition to excessive ED cost, patients also incur costs for being admitted to an inpatient facility and/or jail. These costs, along with Sheriff's Deputy Oversight in the ED, often build on the initial ED cost since the ED is typically the initial access point.

The following table shows the potential ED and inpatient savings of crisis stabilization services. These savings are substantial and exceed the DSRIP funding of the project when taken over the life of the program.

Estimated Annual Savings Crisis Stabilization Services	
Crisis Unit Patients Served	260
ED Cost per Psychiatric Patient[1]	$2,264
ED Savings	**$588,640**
Psychiatric Inp Admit from ED @ 35.1%[1]	91
Inpatient Psychiatric ALOS	10
Cost per Inpatient Psychiatric Day[2]	$685
Inpatient Psych Savings	**$625,131**
Psych ED Patients Jailed @ 5%	13
Days in Jail per Offender[3]	260
Cost of Psychiatric Inmate per Day[3]	$137
Jail Savings	**$463,060**
Sheriff's Deputies per 260 Patients	1
Sheriff's Deputies per Year	$53,500
Deputy Savings	**$53,500**
Total Estimated Savings	**$1,730,331**

1) Emergency Medicine International, 2012
2) CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011

3) National Alliance on Mental Illness
Note: Reflects DY5 Predicted Volume of Service

138365512.*1.1*	***1.13.1***	***1.13.1.A-E***	**Development of behavioral health crisis stabilization services**
Andrews Center			138365512
Related Category 3 Outcome Measure(s):	138365512.***3.1***	*3.IT-9.2*	*ED Appropriate Utilization*

Year 2	Year 3	Year 4	Year 5
Milestone 1: P-3 Develop implementation plans for needed crisis services. **Metric: P-3.1** Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. **Baseline/Goal:** Produce data-driven written action plan **Data Source**: Written plan **Milestone 1 Estimated Incentive Payment:** $ 788,348	**Milestone 2: I-12** Utilization of appropriate crisis alternatives **Metric: I-12.1** Baseline % utilization of appropriate crisis alternatives. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives Denominator: Number of people receiving community behavioral health services in RHP project sites. **Baseline/Goal:** Determine actual baseline % of utilization of crisis alternatives versus estimated baseline 14.2% (200 uses) **Data Source:** Claims, encounter, and clinical record data. **Milestone 2 Estimated Incentive Payment:** $ 865,752	**Milestone 3: I-12** Increased utilization of appropriate crisis alternatives per metrics below: **Metric 1: I-12.1** Increase in utilization of appropriate crisis alternatives. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives Denominator: Number of people receiving community behavioral health services in RHP project sites. **Baseline/Goal:** 10% (220 uses) increase over baseline in utilization of appropriate crisis alternatives as March 31, 2015. Calculated as: (new # -baseline) /baseline **Data Source:** Claims, encounter and clinical record data. **Metric 2: I-12.1** Increase in utilization of appropriate crisis alternatives. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives Denominator: Number of people receiving community behavioral health services in RHP project sites. **Baseline/Goal:** 20% (240 uses) increase over baseline in utilization of appropriate crisis alternatives as Sept 30, 2015. Calculated as: (new # -baseline) /baseline **Data Source:** Claims, encounter and clinical record data. **Milestone 3 Estimated Incentive Payment:** $ 926,134	**Milestone 4: I-12** Increased utilization of appropriate crisis alternatives per metrics below: **Metric: I-12.1** Increase in utilization of appropriate crisis alternatives. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives Denominator: Number of people receiving community behavioral health services in RHP project sites. **Baseline/Goal:** 25% (250 uses) increase over baseline in utilization of appropriate crisis alternatives as March 31, 2016. Calculated as: (new # -baseline) /baseline **Data Source:** Claims, encounter, and clinical record data. **Metric 2: I-12.1** Increase in utilization of appropriate crisis alternatives. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives Denominator: Number of people receiving community behavioral health services in RHP project sites. **Baseline/Goal:** 30% (260 uses) increase over baseline in utilization of appropriate crisis alternatives as Sept 30, 2016. Calculated as: (new # -baseline) /baseline **Data Source:** Claims, encounter and clinical record data. **Milestone 4 Estimated Incentive Payment:** $ 894,819

Year 2 Estimated Total DSRIP Funding:	Year 3 Estimated Total DSRIP Funding:	Year 4 Estimated Total DSRIP Funding:	Year 5 Estimated Total DSRIP Funding:
$788,348	$865,752	$926,134	$894,819
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2 -5):* ***$3,475,052***			

Project Option: 1.9.2 – Improve Access to Specialty Care
Unique Project ID Number: 138374715.1.1 (PASS 1)
Performing Provider Name/TPI: ETMC Pittsburg 138374715

Project Abstract

Provider: East Texas Medical Center Pittsburg (ETMC) is a 25-bed, full-service hospital dedicated to serving the Camp County area with advanced diagnostics, medical and surgical care, outpatient services, and a Level IV trauma center. ETMC's primary service area is Camp County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 120,272.

Intervention: This project increases access to specialty healthcare through recruiting a full-time general surgeon and orthopedic surgeon to establish specialty clinics.

Need for the Project: As sited in the community needs assessment (CN.1, CN.4, and CN.5), our region has insufficient access to specialty care services, high costs due to potentially preventable hospitalizations, and inappropriate emergency room utilization. A general surgeon and orthopedic surgeon will give patients better access to specialty care.

Target Population: The target population is residents of ETMC's Northern Region (Camp, Franklin, Red River, Wood, and Upshur Counties) that currently do not have sufficient access to specialty care. We expect to serve an average of 1,880 new clinic patients per year per provider with a Medicaid and indigent share of 21%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's specialty care capacity, as evidenced by a 66% increase in both orthopedic and general surgery clinic visits over baseline by DY 5, estimated at 2,350 visits per new hire. Patients will benefit from more appointment availability and expanded specialty access.

Category 3 Outcomes: The related category 3 outcome measure is surgical site infection (SSI) rate (IT-4.4) in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC plans to decrease the surgical site infection (SSI) rate —for general surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: ETMC Pittsburg's goal is to be able to treat more patients in the specialty care setting where they can receive more appropriate and proactive care, more efficiently. ETMC Pittsburg plans to expand its specialty care access to providers by recruiting an orthopedic surgeon and a general surgeon. The four-year goal is to see a 66% increase in both orthopedic surgery and general surgery clinic visits.

Historically, resources for specialty services have been extremely limited in the Pittsburg community. There is an imbalance of demand and supply of specialty services due to a shortage of providers in several medical specialties, creating excessive scheduling delays. Under these circumstances, Pittsburg residents have been forced to travel to surrounding areas for their specialty care needs. Without regular access to specialty services, conditions are likely to become acute episodes, putting patients at risk for disability and inpatient admissions. The lack of specialty providers has a significant negative impact on patient satisfaction and quality of care and discourages people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary and specialty care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand specialty care capacity. Expanding specialty care access meets several community needs outlined by RHP 1, including: insufficient access to specialty care services (CN.1), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

The general surgery and orthopedic surgery clinic locations will increase service availability in the Pittsburg community. Maximizing efficiency and specialty care access, the clinics will strive to standardize referrals across the system and conduct quality improvement activities to identify project impacts and opportunities to scale the project to a broader patient population.

Starting point/Baseline: ETMC conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for surgical specialties in several markets; specifically, the ETMC Northern Region is currently underserved by 27 surgical specialists. Patients must travel to Tyler or other larger cities to have access to orthopedic surgery and general surgery. As a part of the Northern Region, ETMC Pittsburg plans to recruit an orthopedic surgeon and general surgeon to serve the Pittsburg community.

Service Area Population 120,272							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
General Surgery	9.7	13.6		11.7	14	5	(9)
OB/GYN	9.9	11.1		10.5	13	2	(11)
Orthopedic Surgery	6.2	5.4		5.8	7	3	(4)
Urology	3.2	2.9		3.1	4	-	(4)
Surgical Specialties					**37**	**10**	**(27)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony and data to model physician need based on current physician supply by specialty, and whether it is adequate given the population base, growth, and future demand. It is a collaborative approach by a range of experts that utilizes comprehensive data sources. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand. This methodology is ideal for projecting needs and uses well regarded source data (MGMA, NAHCMS).

Rationale: Expansion of specialty care is a prerequisite for system-wide improvement, and will have a ripple effect throughout the system. With expanded specialty care access, more patients will have the opportunity to treat episodes early, maintain follow up care, and prevent future hospital stays. Since ETMC Henderson currently does not have a general or orthopedic surgeon and patients must travel for their care, this project represents a new initiative for the performing provider.

Waiting months and/or traveling for a specialty appointment is both frustrating and dangerous: patients and referring physicians are dissatisfied, and the delays in diagnosis and treatment risk preventable patient harm. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to specialty care services. In addition, these issues have less obvious but equally harmful operational consequences: referring physicians must make extreme communication and advocacy efforts to get urgent patients seen, and these patients are then over-booked, which disrupts efficient patient flow and creates further patient waits and dissatisfaction. This project will significantly reduce this system dysfunction for general surgery and provide better access to an underserved area.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-4.4: Surgical site infections (SSI) rates in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC Pittsburg's goal is to reduce the number of surgical site infections (SSI) for general and orthopedic surgery cases. ETMC plans to develop and test data systems to measure surgical site infections (SSI) rates during DY 2. We will collect

preliminary data in DY 3 to serve as a baseline for improvement in the surgical site infection (SSI) rate. ETMC plans to decrease the surgical site infection (SSI) rate —for general and orthopedic surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively.

We propose to increase the overall quality of care and improve the health status of our target population—general and orthopedic surgery patients at ETMC Pittsburg. Recruiting a general and orthopedic surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. With quality improvement oversight, a local general surgeon and orthopedic surgeon and will decrease surgical site infection (SSI) rates, which are directly related high costs due to potentially preventable hospitalizations (CN.4).

Relationship to Other Projects: The Pittsburg community has a shortage of specialty care access and specific need for a general surgeon and orthopedic surgeon. Recruitment of a general and orthopedic surgeon (138374715.1.1) will expand specialty access to those that have untreated surgery needs and improve the overall health of the population.

Recruiting these two physicians will improve patient health outcomes. The expansion of specialty care access through a local general and orthopedic surgeon will expand specialty access and decrease surgical site infections (SSI) rates (138374715.3.1).

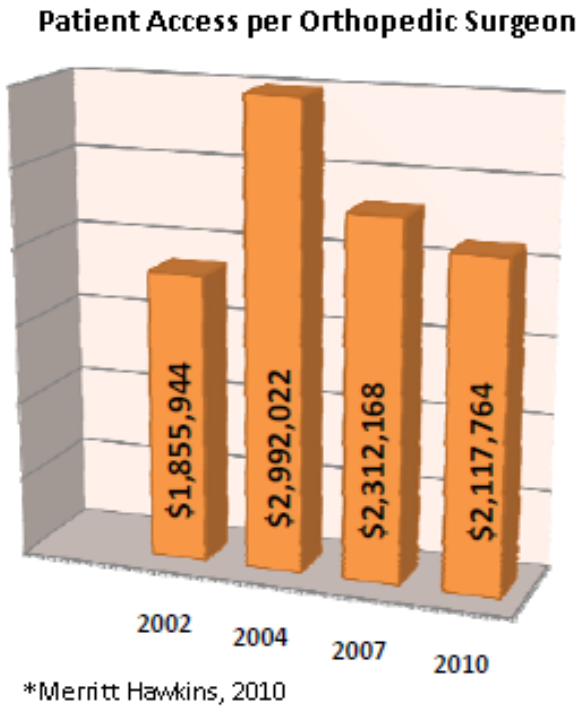
Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

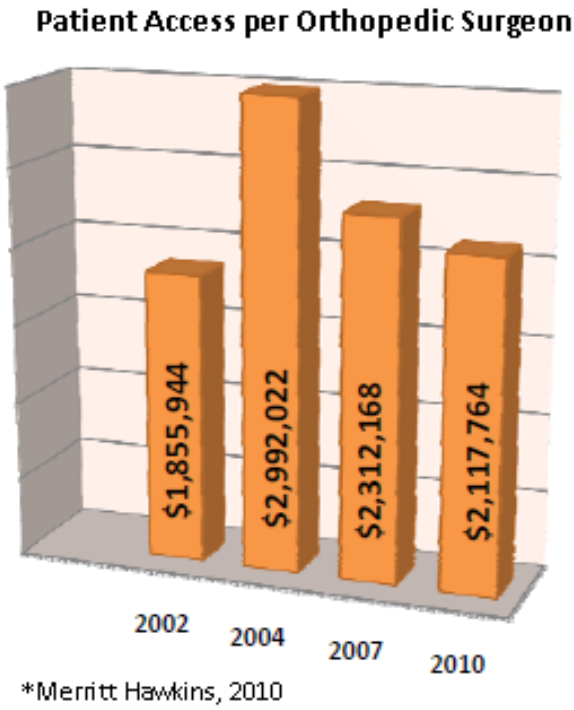
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a general surgeon and an orthopedic surgeon on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional general surgeon and orthopedic surgeon.

The charts below value the access expansion of a general surgeon at $2,112,492 per year and an orthopedic surgeon at $2,117,764. Accordingly, ETMC's DSRIP funding request of

approximately $1,500,000 per year (including Category 1 and 3) is targeted to be less than the value of specialty access expansion so that the CMS program accrues a net benefit.





138374715.1.1	***1.9.2***	***1.9.2.B***	**Increase number of specialty clinic locations**
ETMC Pittsburg			***138374715***
Related Category 3 Outcome Measure(s):	***138374715.3.1***	*3.IT-4.4*	***Surgical site infections (SSI) rates***
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.9.2.P-11 Launch a specialty care clinic—general surgery. **Metric: 1.9.2.P-11.1** Establish specialty care clinics. **Baseline/Goal:** Documentation of specialty care clinic **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 1 Estimated Incentive Payment:** $ 527,098 **Milestone 2: 1.9.2.P-11** Launch a specialty care clinic—orthopedic surgery. **Metric: 1.9.2.P-11.1** Establish specialty care clinics. **Baseline/Goal:** Documentation of specialty care clinic **Data Source**: Registry, EHR, claims or other Performing Provider source	**Milestone 3: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of baseline number of general surgery visits. **Baseline/Goal:** Establish a baseline for specialty clinic volume – estimated at 1410 clinic visits per year– general surgery. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $ 575,036 **Milestone 4: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of baseline number of orthopedic surgery visits. **Baseline/Goal:** Establish a baseline for specialty clinic volume – estimated at 1410 clinic visits per year - orthopedic surgery **Data Source**: Registry, EHR, claims or other Performing Provider source	**Milestone 5: 1.9.2 .I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 33% increase (470) in **general surgery** clinic visits over baseline of 1410 **Data Source**: Registry, EHR, claims or other PP source **Milestone 5 Estimated Incentive Payment:** $ 576,707 **Milestone 6: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** **33%** [470] increase in **orthopedic surgery** clinic visits over baseline of 1410 **Data Source**: Registry, EHR, claims or other PP source	**Milestone 7: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** **66%** increase (940)in **general surgery** clinic visits over baseline of 1410 **Data Source**: Registry, EHR, claims or other PP source **Milestone 7 Estimated Incentive Payment:** $ 476,410 **Milestone 8: 1.9.2. I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** **66%** [940] increase in **orthopedic surgery** clinic visits over baseline of 1410 **Data Source**: Registry, EHR, claims or other PP source

Milestone 2 Estimated Incentive Payment: $ 527,098	**Milestone 4 Estimated Incentive Payment:** $ 575,036	**Milestone 6 Estimated Incentive Payment:** $ 576,708	**Milestone 8 Estimated Incentive Payment:** $ 476,411
Year 2 Estimated Total DSRIP: $1,054,196	Year 3 Estimated Total DSRIP: $1,150,072	Year 4 Estimated Total DSRIP: $1,153,415	Year 5 Estimated Total DSRIP: $952,821
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$4,310,504***			

Project Option: 1.1.1 – Establish more primary care clinics.
Unique Project ID Number: 138913209.1.1 (Pass 1)
Performing Provider Name/TPI: Titus Regional Medical Center (TRMC) 138913209

Project Abstract

Provider Description:
Titus Regional Medical Center ("TRMC") is a **174** bed hospital in Mount Pleasant, Texas serving the Northeast Texas area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level III Lead trauma center. Mount Pleasant is the county seat of Titus County which has a population of 32,334 per the 2010 Census data and covers 406 square miles. The total service area population of TRMC covers fifteen counties with a total service area population of approximately 220,874.

Interventions:
This project will build a new Family Care Center in an underserved location of Mount Pleasant and provide the community an alternative to the Emergency Room.

Need for the Project:
As sited in the community needs assessment (CN.1 and CN.5), our region has insufficient access to primary care services and inappropriate emergency room utilization. The Mount Pleasant area currently has limited options for primary healthcare with the majority of the primary care providers adjacent to the hospital and closer to the interstate. In addition, the Emergency Room is used to provide primary care healthcare after normal business hours and on weekends creating an inefficient and high cost of service. Access to a Family Care Center with additional hours will improve patient's access to primary care and reduce the use of emergency room for non-emergent visits reducing the overall cost of care. Other health systems will be interested in the outcome of this project and may want to replicate them.

Target Population:
The target population is residents of TRMC's fifteen county service area in Northeast Texas that need access to a primary care physician or access to primary care after normal business hours. We expect the Family Care Center to serve at least 6,450 patient encounters in DY 5. Our current payor mix includes a Medicaid eligible share of 21% and uninsured/indigent share of 27%.

Category 1 Expended Patient Benefits:
The project seeks to provide at least 20 patient encounters per day in DY 4 (approximately 5,140 annual patient encounters) and at least 25 patient encounters per day in DY 5 (approximately 6,450 annual patient encounters).

Category 3 Outcomes:
Our goal is to reduce the percentage of lower level Emergency Room visits while improving Patient Satisfaction scores in the Family Care Center. The development of a Family Care Center will offer the residents of our area access to primary care physicians in the providing right care

and right setting through appropriate ED utilization (138913209.3.2). In addition, patient satisfaction scores will increase due to new access to primary care physicians, additional hours of operation, shorter wait times in both the primary care setting and the emergency room setting and appropriateness of care (138913209.3.1).

Project Narrative

Project Description:

TRMC's mission is to be able to treat more patients in the primary care setting where they can receive more appropriate and proactive care, more efficiently. TRMC's goal is to provide the underserved population of Northeast Texas who do not have access to primary care or use the emergency room for their basic healthcare needs. TRMC plans to expand its primary care access by opening a Family Care Center to provide primary care physicians, lab and X-ray capabilities. The DY 5 goal is to assist at least 25 encounters per day in DY 5 (approximately 6,450 annual patient encounters).

Consistent with the overarching goal and vision of RHP 1, TRMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of TRMC. Northeast Texas is an area where patients face many challenges in accessing primary and specialty care, preventive care, and chronic disease management. Titus County has a population of 32,334 per the 2010 Census data with 48.2% Caucasian, 40.6 Hispanic and 10.1% African American. The average median household income for Titus County is $39,423. In Titus County as elsewhere, low income, uninsured and minority populations are disproportionately medically disenfranchised. These individuals often have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling, long waiting times and denial by physicians to accept all forms of medical coverage have a significant negative impact on patient satisfaction, provider satisfaction and quality of care discouraging people from using health care proactively. As a result of limited primary care, many patients are cared for exclusively in specialty care clinics and/or emergency rooms; these settings are not designed to provide comprehensive assessment, preventive care and coordination. With expanded primary care capacity, more patients can have access to primary and preventive care.

The goal of this project is for TRMC to build a new Family Care Center in an underserved location of the county. In an effort to meet the needs of our community, the new Family Care Center will also have expanded hours compared to our current local primary care providers. This facility will increase TRMC's ability to provide treatment for more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. Primary care providers serve as the patient's first point of entry into a health care system and are essential for providing timely preventive visits and effective coordination of health care services. Titus County has about 30% of children identified as living at or below the poverty level compared to 26% for the state average and 13% for the national benchmark. Primary care

access is critical to this population, with the fastest growing ethnic group regardless of age, being Hispanics.

Challenges: An increasing low income population growth has increased the demand for primary care access and wait-time for the next available appointment. Our direct care centers are not available after hours or on the weekends. More providers are necessary to provide for the increasing number of patients. This shortage of primary care providers has resulted in limited options for Medicaid and Medicare patients and extremely limited resources for uninsured patients without a payer source in every community.

Titus County has a patient to primary care physician ratio of 1,411:1 compared to the state average of 1,050:1 and the national benchmark of 631:1. The uninsured percentage for Titus County is 30% compared to the state average of 26% and national benchmark of 11%. . Preventable hospital stays in Titus County was 94 compared to the state average of 73 and the national benchmark of 49. These numbers support the need for additional primary care capacity who meet the needs of all levels of income.

The increase in patients seeking care in the Emergency Department that are non-emergent has increased the cost for level of service required. In addition, the patients who need advanced level care in an acute care hospital are forced to wait additional time due to these non-emergent visits. With educational outreach and empowering patients to participate in their care, the primary care setting can be, and should be, more often the right place for the right care at the right time.

Regional Goals:
This project will complement the regional goal identified in the Community Needs Assessment: "CN.1 - Insufficient access to primary and specialty health care services." & "CN.5 – Inappropriate emergency department utilization." Other health systems will be interested in the outcome of this project and may want to replicate them.

Five-Year Outcomes:
The minimum expected five-year outcome of this project is to provide care in our Family Care Center for a minimum of twenty-five (25) patients per day by the end of the five years. The improvement in access for patients through expanding primary care will result in extended hours of access, more providers, and a new site of services, all of which will impact low income and minority patients. The overall effect of expansion of primary care services will be an improvement in patient satisfaction scores.

Starting Point/Baseline:
TRMC's effort to build this facility is a new line of business for TRMC so there is no baseline for number of patients seen in a Family Care Center. As for the percentage reduction in the lower level of Emergency Room visits to TRMC due to the opening of the Family Care Center, TRMC will use May 1, 2012 through December 31, 2012 as the baseline for this calculation. TRMC

implemented a tracking system on May 1st which will enable the hospital to track this level of visit. The baseline by month has been included below:

Level:	**05/31/2012**	**06/30/2012**	**07/31/2012**	**08/31/2012**	**09/30/2012**	**10/31/2012**
Unassigned	58	64	64	74	48	41
Level 1 - Unstable (Highest)	7	12	7	7	6	12
Level 2 - High Risk	170	125	105	151	152	196
Level 3 - Two or Less Resources	1,029	982	1,091	1,080	1,169	1,219
Level 4 - One Resource	508	468	433	422	396	344
Level 5 - No Resources (Lowest)	135	110	104	103	83	85
Total	**1,907**	**1,761**	**1,804**	**1,837**	**1,854**	**1,897**

% Excluding Unassigned:	**05/31/2012**	**06/30/2012**	**07/31/2012**	**08/31/2012**	**09/30/2012**	**10/31/2012**
Level 1 - Unstable (Highest)	0.38%	0.71%	0.40%	0.40%	0.33%	0.65%
Level 2 - High Risk	9.19%	7.37%	6.03%	8.56%	8.42%	10.56%
Level 3 - Two or Less Resources	55.65%	57.87%	62.70%	61.26%	64.73%	65.68%
Level 4 - One Resource	27.47%	27.58%	24.89%	23.94%	21.93%	18.53%
Level 5 - No Resources (Lowest)	7.30%	6.48%	5.98%	5.84%	4.60%	4.58%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Rationale: TRMC plans to achieve expansion of primary care capacity through Project Option 1.1.1 – Establish more primary care clinics. We believe it is our responsibility to ensure access to health care and knowledge to enhance the health of individuals and to make improvements in quality and cost. Because primary care providers are typically the first point of contact for patients seeking health care, it is often described as the foundation of our health care system. Patients in our community have been asking for better access to primary health care services, better quality of care, and more health promotion and disease prevention services.

A RAND Corporation published in September 7, 2010 found about 17 percent of all visits to hospital emergency departments across the United States could be treated at retail medical clinics or urgent care centers, potentially saving $4.4 billion annually in health care costs. Conditions that could be treated safely outside hospitals include minor infections, strains, fractures and lacerations, according to findings published in the September 2010 edition of the journal *Health Affairs*. RAND researchers analyzed information about people who visited retail medical clinics and urgent care centers and compared it to profiles of patients who visited hospital emergency departments during 2006. They examined issues such as the severity of injuries and illnesses seen in emergency departments, as well as the volume and mix of cases seen when alternative care settings are open. Based upon the comparisons, researchers estimated that 13.7 percent of all emergency department visits reviewed could have been treated in a retail medical clinic, although that proportion decreases to about 8 percent when the analysis is restricted to visits that occur when retail clinics typically are open. An additional 13.4 percent of all hospital emergency department visits could be treated at an urgent care center, although that proportion decreases to about 9 percent when cases are restricted to those seen when the centers typically are open. Overall, although the researchers estimated that 27.1 percent of all hospital emergency department visits could be managed at a retail clinic

or urgent care center, only 16.8 percent could be managed during the hours the emergency department alternatives typically are open.

This project is a new endeavor for TRMC. The addition of a Family Care Center provides additional primary care availability for the residents of Titus County while addressing the increased costs of treatment of the needs in the Emergency Room as noted above.

Community Needs:
All required components of this project will be addressed by this endeavor and are needed in this region. The opening of the Family Care Center addresses the Region's Community Needs:

CN.1 - Insufficient access to primary and specialty health care services.
CN.5 – Inappropriate emergency department utilization.

Related Category 3 Outcome Measures:
The expected results of the primary care expansion initiative are to make access to healthcare easier by increasing the number of primary care providers, adopting same-day scheduling to ensure timely appointments, and ensuring the ability to access primary care outside of regular hours. To demonstrate this, TRMC has selected two Related Category 3 Outcome Measures:

OD – 6 Patient Satisfaction

IT – 6.1: *Percent improvement over baseline of patient satisfaction scores.*
TRMC will use two patient satisfaction surveys to evaluate the success of our Category 1 project: patient satisfaction improvements for the Family Care Center and patient satisfaction improvements for the Emergency Room.

OD – 9 Right Care, Right Setting

IT – 9.2: *ED appropriate utilization.*
TRMC will measure the achievement of this measure by reducing the percentage of ED visits categorized as Level 4 and Level 5 visits as a percentage of all ED Visits.

Improvement in Patient Satisfaction Surveys along with the reduction of lower categorized ED visits meets the needs of our community and provides a direct impact to the improvement of healthcare in our area.

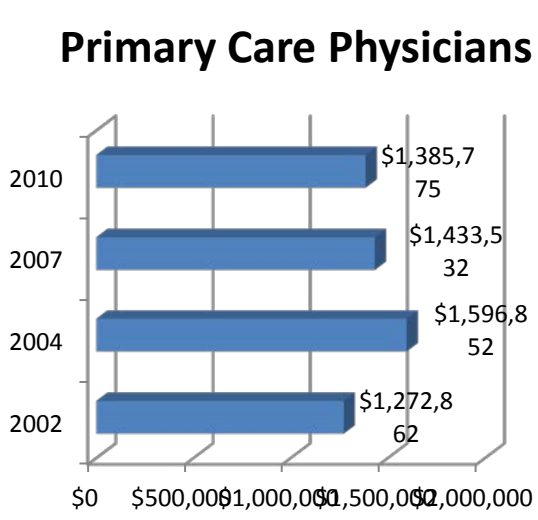
TRMC's effort to build this facility is a new line of business for TRMC so there is no baseline for number of patients seen in a Family Care Center. As for the percentage reduction in the lower level of Emergency Room visits to TRMC due to the opening of the Family Care Center, TRMC will use May 1, 2012 through December 31, 2012 as the baseline for this calculation.

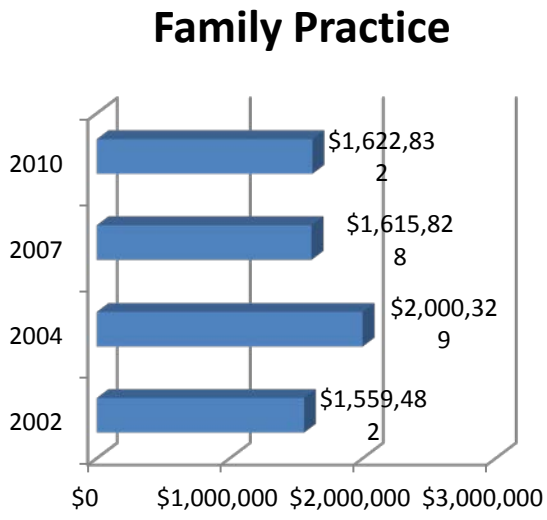
Relationship to Other Projects and Measures:
All of the projects of TRMC complement each other to meet the transformational goals and the three aims of CMS. Expansion of primary care access, improved access to specialty care, reduction in expenses through cost containment and the implementation of a Rapid Medical Exam in the ED are consistent with each other and complement the goals of each project.

Relationship to Other Performing Projects in the RHP1:
Increasing primary care is a major initiative of the entire region. Many of the other regional partners have selected this project, including Andrews Center, East Texas Medical Center, St. Michaels Health System, Mother Frances Hospital, The Burke Center, University Physicians, and Hunt Regional Medical Center. The geographic area covered in RHP Plan for this region lends itself to multiple entities expanding primary care. It is our full intention to participate and lead some of the learning collaborative opportunities to share best practices.

Plan for Learning Collaboratives:
Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. TRMC believes in and supports the value of learning collaboratives and plans to support the plans of Region 1. The system pledges to develop, support, participate, and lead the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to have our collaboratives inform others of our experiences and best practices acquired and learn from others in the state. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, TRMC, and Mother Frances Hospital, have met to discuss the project planning process and selection of projects.

Project Valuation: Project Valuation:
Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional physician.





The addition of Primary Care physicians in the Family Care Center and additional hours of operation will reduce the unnecessary visits to the emergency room by our residents. The current Level 4 and Level 5 visits to our emergency room are approximately 30% resulting in approximately 6,598 visits which have the potential to be treated in other settings. Assuming a 5% reduction in the Level 4 and Level 5 visits, TRMC projects an estimated cost savings of approximately $250,000 per year.

Savings - Reduction Level IV & V

Total ED Visits (annual)	21,993
Current Avg Level 4 or Below	30%
ED Visits Level 4 or Below	6,598
Reduction of Level 4 or Below	5.0%
Estimated ED Visits Avoided	330
Average ED Visit	$750
Estimated Annual Savings	**$247,416**

The charts and data above value Primary Care Physicians in Family practice at $1.625 million per year. In addition, the implementation of a Family Care Center will result in at least $250,000 per year in cost of savings from ED. Accordingly, TRMC's average DSRIP funding request of approximately $1,337,408 per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

138913209.1.1	*1.1.1*	*1.1.1*	**1.1 - Expand Primary Care Capacity**	
Titus Regional Medical Center				138913209
Related Category 3 Outcome Measure(s):	138913209.3.1 138913209.3.2	*IT – 6.1* *IT – 9.2*	Percent improvement over baseline of patient satisfaction scores. ED appropriate utilization.	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Establish additional/expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space. Baseline: 0 – New clinic service, so there are no providers, staffing or patient visits for this service as of 9/30/12. Goal: Submission of Business Plan for opening Family Care Center to CEO for approval. Data Source: Documentation of the Business Plan for the Family Care Center. **Milestone 1 Estimated Incentive Payment*:* $1,128,593**	**Milestone 2 P-1**: Establish additional/expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space. Baseline: 0 – New clinic service, so there are no providers, staffing or patient visits for this service as of 9/30/12. Goal: Opening of Family Care Center. Data Source: Documentation of patients seen in the Family Care Center. **Milestone 2 Estimated Incentive Payment: $1,154,282**		**Milestone 3 I-12**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 – New clinic service, so there are no providers, staffing or patient visits for this service as of 9/30/12. Goal: 20 Encounters Per Day at the Family Care Center. Data Source: Electronic Medical Records from Family Care Center. **Milestone 4 Estimated Incentive Payment: $1,152,493**	**Milestone 4 I-12**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 – New clinic service, so there are no providers, staffing or patient visits for this service as of 9/30/12. Goal: 25 Encounters Per Day at the Family Care Center. Data Source: Electronic Medical Records from Family Care Center. **Milestone 4 Estimated Incentive Payment: $930,584**
Year 2 Estimated Milestone Bundle Amount: $1,128,593	**Year 3 Estimated Milestone Bundle Amount: $1,154,282**		**Year 4 Estimated Milestone Bundle Amount: $1,152,493**	**Year 5 Estimated Milestone Bundle Amount: $930,584**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $4,365,952				

Project Option: 1.9.2 – Improve access to specialty care
Unique Project ID Number: 138913209.1.2 (Pass 2)
Performing Provider Name/TPI: Titus Regional Medical Center (TRMC) 138913209

Project Abstract

Provider Description:
Titus Regional Medical Center ("TRMC") is a **174** bed hospital in Mount Pleasant, Texas serving the Northeast Texas area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level III Lead trauma center. Mount Pleasant is the county seat of Titus County which has a population of 32,334 per the 2010 Census data and covers 406 square miles. The total service area population of TRMC covers fifteen counties with a total service area population of approximately 220,874.

Interventions:
This project will recruit an endocrinologist to Titus County and increase the number of patients seen by the Diabetes Self-Management Education Program Team.

Need for the Project:
The Mount Pleasant service area currently does not have an endocrinologist and above average population of high risk residents. As sited in the community needs assessment (CN.1, CN.3, CN.4, CN.5 and CN.6), our region has insufficient access to specialty care services, high rates of chronic disease, high costs due to potentially preventable hospitalizations, inappropriate emergency room utilization and the need for efficient and effective health care delivery. Recruitment of an endocrinologist and increased visits in our Diabetes Self-Management Education Program Team will give patients access to specialty care, improve treatment of our patients, improve patient outcomes and reduce cost of care. Other health systems will be interested in the outcome of this project and may want to replicate them.

Target Population:
The target population is our patients who are high risk for the complications of diabetes. The residents of our area comprise a Medicaid eligible share of 21% and uninsured/indigent share of 27%. This target population has the need for education and early intervention to avoid long term costs of the complications of diabetes.

Category 1 Expended Patient Benefits:
The project seeks to provide an endocrinologist at least one day per week and increase the number of encounters seen by the endocrinologist and the Diabetes Self-Management Education Program Team by 10% over DY 3.

Category 3 Outcomes:
Through the increased activity of Diabetes Self-Management Education Program and access to an endocrinologist (138913209.1.2), 30 Day Readmissions with an original diagnosis of diabetes will be decreased (138913209.3.4). This was chosen as the outcome measure because it is

closely aligned with the purpose of this Category 1 project. Access to a health professional and improvements in their perceived level of health literacy will assist lower income members of our community because of their limited access to transportation and physician care.

Project Narrative

Project Description:
TRMC is located in Northeast Texas in Mount Pleasant. Titus County has a population of 32,334 per the 2010 Census data with 48.2% Caucasian, 40.6 Hispanic and 10.1% African American. The average median household income for Titus County is $39,423. In Titus County as elsewhere, low income, uninsured and minority populations are disproportionately medically disenfranchised. These individuals often have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death.

Titus County currently does not have an endocrinologist assisting patients in this area. However, TRMC does offer a Diabetes Self-Management Education Program. The program assists patients with the management and education on Diabetes. Through one on one and group counseling, patients are given the information they need to assist with management of diabetes. Nutritional advice, exercise planning and medication education are a few of the many advantages the program gives those diagnosed with diabetes. In addition, the team visits patients in the hospital to assist with the education of their diabetes.

TRMC's goal is to be able to treat more patients in the specialty care setting where they can receive more appropriate and proactive care, more efficiently. TRMC plans to expand its specialty care access to providers by recruiting at least a part-time endocrinologist to the Mount Pleasant area and increasing the number of visits to the Diabetes Self-Management Education Program.

Challenges:
An increasing low income population growth has increased the demand for diabetic prevention in the Titus County area. According to the Texas Behavorial Risk Factor Surveillance System (BRFSS) in 2010 Center for Health Statistics, diabetes prevalence in Hispanics was 11.0% compared to whites was 8.2%. Per the BRFSS, a decreasing gradient was seen in prevalence of diabetes with an increase in education status. Adults with some college or higher education had significantly lower prevalence of diabetes as compared to adults with less than high school education. As a result of Titus County's ethnic compilation and education background, the community has a higher than normal risk to Diabetes.

Regional Goals:
The Mount Pleasant service area currently does not have an endocrinologist and above average population of high risk residents. As sited in the community needs assessment (CN.1, CN.3, CN.4, CN.5 and CN.6), our region has insufficient access to specialty care services, high rates of chronic disease, high costs due to potentially preventable hospitalizations, inappropriate

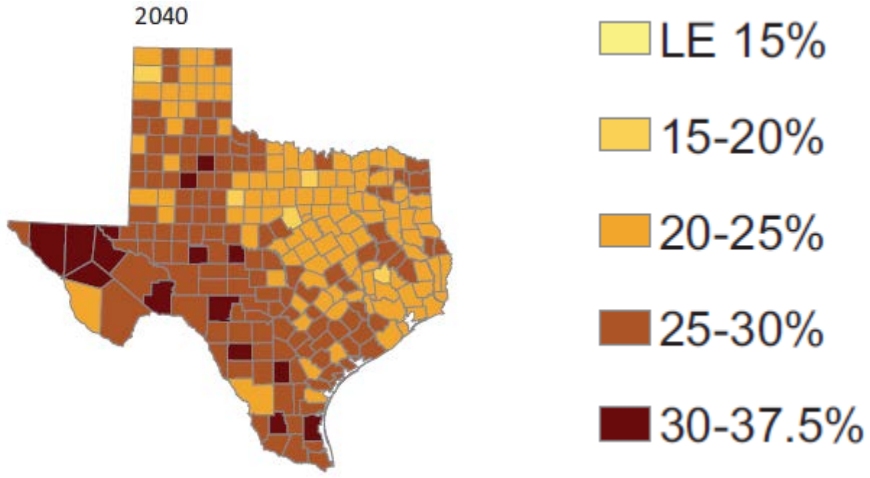
emergency room utilization and the need for efficient and effective health care delivery. Recruitment of an endocrinologist and increased visits in our Diabetes Self-Management Education Program Team will give patients access to specialty care, improve treatment of our patients, improve patient outcomes and reduce cost of care. Other health systems will be interested in the outcome of this project and may want to replicate them.

Five-Year Outcomes:
The minimum expected five-year outcome of this project is to provide an endocrinologist in the Mount Pleasant area at least weekly and to increase the number of visits to the Diabetes Self-Management Education Program/endocrinologist by 10% over DY 3.

Starting Point/Baseline:
The Diabetes Self-Management Education Program saw 205 patients with Type 1 or Type 2 diabetes in fiscal year 2012, a 24% increase from the 166 in fiscal year 2011. Currently, Titus County does not have an endocrinologist actively seeing patients within the county.

Rationale:
Increasing capacity for delivery of primary care and management of chronic disease was the number one goal of TRMC's Community Health Needs Assessment completed in 2012 with the recruitment of an endocrinologist as a common request of the community surveyed.

Per the Summary Report on Diabetes Projections in Texas, 2007 to 2040, diabetes is the sixth leading cause of death in Texas and has created a burden on the healthcare system. Texas is among the states with the highest incidence rates for diabetes. New cases of diabetes have been soaring in the past decade. During the period from 1995-1997 to 2005-2007, age-adjusted incidence rate for diabetes more than tripled and increased from 3.6 to 11.1 per 1,000 persons in Texas. This latest incidence rate means that an average of 156, 000 new cases of diabetes were added each year to the State. Per the report, rural counties had higher percentages of diabetes due to low rates of insurance coverage and low physician-to-population ratios. The Texas projections for diabetes by county shows Titus in the 25 – 30% by 2040:



Projected Percent of the Population with Diabetes by County, 2020 to 2040

	Diabetes 2020	Diabetes 2030	Diabetes 2040
State of Texas	17.1	20.8	23.8
Titus County	18.1	22.1	25.3

Projected Numbers of Persons with Diabetes by County, 2020 to 2040

	Diabetes 2020	Diabetes 2030	Diabetes 2040
State of Texas	3,903,995	5,783,481	7,980,225
Titus County	4,789	6,480	7,881

The reduction of the high costs due to potentially preventable hospitalizations is one of the project needs noted in TRMC's and the Region's Community Assessment. The cost of hospital charges related to potentially preventable hospitalizations incurred by diabetes from 2005 – 2010 was $4.8 million.

Titus County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Titus County** received **$32,856,899** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Titus County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	96	143	149	119	7	15	529	$17,379	$9,193,622	$409
Dehydration	16	22	33	30	5	0	106	$11,774	$1,248,040	$56
Urinary Tract Infection	39	61	53	41	10	17	221	$13,231	$2,924,125	$130
Angina (without procedures)	12	0	9	9	0	0	30	$12,918	$387,547	$17
Congestive Heart Failure	86	115	86	96	19	23	425	$20,553	$8,735,194	$389
Hypertension (High Blood Pressure)	22	20	26	17	0	0	85	$11,879	$1,009,681	$45
Asthma	8	17	19	11	0	0	55	$14,691	$807,979	$36
Chronic Obstructive Pulmonary Disease	29	30	37	75	11	16	198	$18,925	$3,747,083	$167
Diabetes Short-term Complications	9	10	11	16	0	0	46	$18,920	$870,319	$39
Diabetes Long-term Complications	17	18	23	24	9	5	96	$40,972	$3,933,308	$175
TOTAL	**334**	**436**	**446**	**438**	**61**	**76**	**1,791**	**$18,346**	**$32,856,899**	**$1,463**

Source: Center for Health Statistics, Texas Department of State Health Services
The number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS.
Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Diabetes education and physician monitoring will directly correlate to improved healthcare in Titus County. In addition, an endocrinologist in Titus County would increase the number of insulin pumps which are prescribed in this area giving our residents another advantage.

Community Needs: All required components of this project will be addressed by this endeavor and are needed in this region. This project addresses the Region's Community Needs:

CN.1 - Insufficient access to primary and specialty health care services.

CN.3 – High rates of chronic disease.
CN.4 – High costs due to potentially preventable hospitalizations.
CN.5 – Inappropriate emergency department utilization.
CN.6 - The need for efficient and effective health care delivery.

Related Category 3 Outcome Measures:
The expected results of the improved access to specialty care expansion is to reduce the number of patients with diabetes being readmitted into the hospital within 30 days. TRMC is addressing the following domain:

OD – 3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
IT – 3.3: *Diabetes 30 day readmission rate*

Relationship to Other Projects and Measures:
All of the projects of TRMC complement each other to meet the transformational goals and the three aims of CMS. Expansion of primary care access, improved access to specialty care, reduction in expenses through cost containment and the implementation of a Rapid Medical Exam in the ED are consistent with each other and complement the goals of each project.

Relationship to Other Performing Projects in the RHP1:
Increasing specialty care is a major initiative of the entire region. Many of the other regional partners have selected this project, including East Texas Medical Center, Mother Frances Hospital, and University Physicians. The geographic area covered in RHP Plan for this region lends itself to multiple entities expanding specialty care. It is our full intention to participate and lead some of the learning collaborative opportunities to share best practices.

Plan for Learning Collaboratives:
Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. TRMC believes in and supports the value of learning collaboratives and plans to support the plans of Region 1. The system pledges to develop, support, participate, and lead the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to have our collaboratives inform others of our experiences and best practices acquired and learn from others in the state. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, TRMC, and Mother Frances Hospital, have met to discuss the project planning process and selection of projects.

Project Valuation:
American Association of Diabetes Educators published a fact sheet in 2010 detailing the average savings from a patient receiving diabetes education to be $918 per year. In addition, the study showed the hospitalization rate for patients with no educational visits to be 38.1 per person per 100 years while the rate of patients with educational visits to be 25.0 per person per 100 years with education.

Savings - Diabetes Education	
Patients Seen By Diabetes Education	205
Average Savings per Patient	$918
Estimated Annual Savings	**$188,190**

Medical Group Management Association's 2011 Physician Compensation and Production Survey calculated the mean for an endocrinologist's collections for professional charges to be approximately $417,000 per year.

The charts and data above value Neurology at $417,000 per year and cost of savings of approximately $190,000 per year. Accordingly, TRMC's average DSRIP funding request of approximately $172,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

138913209.1.2	*1.9.2 A - D*	*1.9.2 A - D*	**1.9 - Expand Specialty Care Capacity**	
Titus Regional Medical Center				138913209
Related Category 3 Outcome Measure(s):	138913209.3.4	*IT – 3.3*	Diabetes 30 Day Readmission Rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: 1.9.2 A-D. P-11: Launch/expand a specialty care clinic—endocrinology. **Metric: 1.9.2 A-D P-11.1** Establish/expand specialty clinics. **Baseline/Goal:** Documentation of new/expanded specialty care clinic. **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 1 Estimated Incentive Payment*:* $137,286**	**Milestone 2: *1.9.2 A - D* I-23**: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2 A-D. I-23.1** Documentation of baseline number of visits. **Baseline/Goal:** Establish a baseline for specialty clinic volume. **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment: $143,637**		**Milestone 3: 1.9.2 A-D. I-23**: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2 A-D. I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 5% increase in clinic visits over baseline, calculated as (new # - baseline)/baseline **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment: $146,106**	**Milestone 4: 1.9.2 A-D. I-23**: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2 A-D. I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 10% increase in clinic visits over baseline, calculated as (new # - baseline)/baseline **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment: $118,822**
Year 2 Estimated Milestone Bundle Amount: $137,286	**Year 3 Estimated Milestone Bundle Amount: $143,637**		**Year 4 Estimated Milestone Bundle Amount: $146,106**	**Year 5 Estimated Milestone Bundle Amount: $118,822**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $545,851				

Project Option: 1.9.1 – Expand high impact specialty care capacity in most impacted medical specialties.
Unique Project ID Number: 138913209.1.3 (Pass 3b)
Performing Provider Name/TPI: Titus Regional Medical Center (TRMC) 138913209

Project Abstract

Provider Description:
Titus Regional Medical Center ("TRMC") is a **174** bed hospital in Mount Pleasant, Texas serving the Northeast Texas area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level III Lead trauma center. Mount Pleasant is the county seat of Titus County which has a population of 32,334 per the 2010 Census data and covers 406 square miles. The total service area population of TRMC covers fifteen counties with a total service area population of approximately 220,874.

Interventions:
This project increases the capacity of specialty healthcare in Northeast Texas through TRMC achieving the Texas certification as a Level II Primary Stroke Center and the recruitment of a full-time neurologist to establish a specialty clinic location.

Need for the Project:
As sited in the community needs assessment (CN.1, CN.3, CN.4, CN.5 and CN.6), our region has insufficient access to specialty care services, high rates of chronic disease, high costs due to potentially preventable hospitalizations, inappropriate emergency room utilization and the need for efficient and effective health care delivery. Implementation of the requirements for designation of a Level II Primary Stroke Center and the recruitment of a neurologist will give patients access to specialty care, improve treatment of our patients, improve patient outcomes and reduce cost of care. Other health systems will be interested in the outcome of this project and may want to replicate them.

Target Population:
The target population is residents of TRMC's fifteen county service area in Northeast Texas that currently do not have sufficient access to neurological and stroke support. In addition, the access to a Level II Primary Stroke Center targets the 132,950 people in Northeast Texas who are not within sixty minutes of a Primary Stroke Center. We expect to serve approximately 150 stroke patients per year and approximately 1,500 neurological encounters per year with a Medicaid eligible share of 21% and uninsured/indigent share of 27%.

Category 1 or 2 Expected Patient Benefits:
The project seeks to improve TRMC's specialty care capacity, as evidenced by a 10% increase in neurology encounters over baseline by DY 5. Patients will benefit from expanded specialty access.

Category 3 Outcomes:

Through implementation of the processes to achieve Level II Primary Stroke Center and access to a neurologist (138913209.1.3), the Stroke (CVA) 30 day readmission rate will be decreased. This measure estimates the hospital-level, risk-standardized rate of unplanned, Stroke (CVA) readmissions after admission for Stroke (CVA) within 30 days of hospital discharge for patients aged 18 and older (138913209.3.6). This was chosen as the outcome measure because it is closely aligned with the purpose of this Category 1 project. Access to a health professional and improvements in their perceived level of health literacy will assist lower income members of our community because of their limited access to transportation and physician care.

Project Narrative

Project Description:
TRMC's mission is to be able to treat more patients in the specialty care setting where they can receive more appropriate and proactive care, more efficiently. TRMC's goal is to provide the underserved population of Northeast Texas, who are not within 60 minutes of a Level II Primary Stroke Center, a facility which can stabilize and treat acute stroke patients providing initial acute care. Primary Stroke Centers are able to appropriately use t-PA and other acute therapies such as stabilization of vital functions, provision of neuroimaging procedures, and management of intracranial lesions and blood pressures. TRMC plans to expand its specialty care access to providers by achieving this level of designation and the recruitment of a neurologist. The DY 5 goal is to assist approximately 150 stroke patients per year and approximately 1,500 neurological encounters per year.

Consistent with the overarching goal and vision of RHP 1, TRMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of TRMC. Northeast Texas is an area where patients face many challenges in accessing primary and specialty care, preventive care, and chronic disease management. Titus County has a population of 32,334 per the 2010 Census data with 48.2% Caucasian, 40.6 Hispanic and 10.1% African American. The average median household income for Titus County is $39,423. In Titus County as elsewhere, low income, uninsured and minority populations are disproportionately medically disenfranchised. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, TRMC is proposing to expand high impact specialty care capacity. Expanding specialty care access meets several community needs outlined by RHP 1, including: insufficient access to specialty care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), inappropriate emergency room utilization (CN.5), and efficient and effective health care delivery (CN.6).

We will meet the required components of our project through providing access for Northeast Texas to a Level II Primary Stroke Center and proposing to support access to providers in the

underserved area by recruiting a neurologist to provide coverage in the Mount Pleasant area. The new neurologist will increase service availability in the Northeast Texas community. In order to maximize efficiency and specialty care access, TRMC will strive to implement quality improvement activities to identify project impacts and opportunities to expand the coverage and capabilities of this project.

Starting point/Baseline:
The starting point and baseline for this project consists of our gap analysis and community needs study for neurology and stroke management. A baseline for neurological encounters will be established in DY 4. The benefits of which can be documented and studied through obtaining and maintaining a Level II Primary Stroke Center, improved efficiency of patient care, fewer peristroke complications, increased use of acute stroke therapies, reduced morbidity and mortality, improved long-term outcomes, reduced costs to the healthcare system and increased patient satisfaction. Neurological encounters include stroke treatment as well as the diagnosis, treatment and management of disorders of the brain and nervous system such as Dementia, Alzheimer's, Parkinson's, Epilepsy, Migraine, ALS, Multiple sclerosis (MS), and other Neuromuscular Conditions.

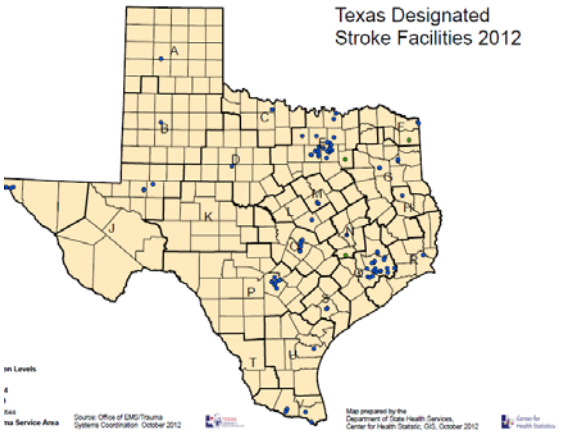
Rationale:
Stroke is ranked as the third leading cause of death in the United States behind heart disease (with which it is closely linked) and cancer.[1] Stroke affects more than 700,000 individuals annually in the United States (approximately one person every 45 seconds). About 500,000 of these are first attacks, and 200,000 are recurrent attacks. Stroke is the leading cause of disability among adults in the United States. Four of five families will be somehow affected by stroke over the course of a lifetime.

Many US hospitals lack the necessary infrastructure and organization required to triage and treat stroke patients quickly and efficiently, and do not deliver adequate stroke care. Primary Stroke Centers were created to diagnose, treat and provide early rehabilitation to stroke patients. The addition of these facilities will reduce the occurrence, disabilities and deaths associated with strokes. Primary Stroke Centers must meet the following guidelines:

- A CT scan or MRI scanner must be available 24 hours each day, and should be reserved for stroke patients within 25 minutes of being ordered
- Access to neurosurgical services
- Laboratory tests of patients with acute stroke must be completed within 45 minutes of being ordered
- Written interpretation of CT or MRI studies must be available within 45 minutes
- A written t-PA protocol must exist in the emergency department
- The medical organization must have a declared and established commitment for acute stroke care
- The hospital must have written acute stroke "clinical pathways" or "care maps"

- An acute stroke team, including a physician and at least one other healthcare professional, must be available around the clock
- Follow long-term stroke treatment outcomes, and design quality improvement activities
- Emergency staff must have completed formal training in acute stroke treatments
- The hospital must have a "stroke unit"
- There must be a designated stroke center director
- Stroke center medical director and all emergency room physicians must have 8 hours of annual education related to stroke
- The stroke team must schedule stroke medical education sessions for stroke staff
- The hospital must provide formal stroke training for ambulance personnel

Currently, Texas has 103 designated stroke facilities. Texas only has 1 Comprehensive (Level I) Stroke Facility. Texas has 95 Primary (Level II) Stroke Facilities and 3 Support (Level III) Stroke Facilities. The closest stroke facilities to the east of Mount Pleasant are Christus St. Michael and Wadley in the Texarkana area. To the South of Mount Pleasant, two stroke facilities are located in Tyler and one facility in Longview. All five of these locations are just outside of the sixty minute area to Mount Pleasant. To the west of Mount Pleasant, Garland is the closest area with a stroke center and is about 120 minutes from Mount Pleasant. This area to the west creates a gap in coverage of Northeast Texas for stroke Centers. In 2008, the American Heart Association and American Stroke Association published the population of Texans who were within 60 minutes of a Primary Stroke Center and documented 81.9% of Texans were within the 60 minute area. The study identified nine city hospitals in the state of Texas to target for the addition of a Primary Stroke Centers to improve the overall coverage of stroke centers in Texas by 2,052,038, a coverage of 90.5%. Mount Pleasant was listed on this targeted list with the possible target population of 132,950 people who could be added to the 60 minute coverage with the addition of Primary Stroke Center.



In addition to stroke support, the requirements for Level II Primary Stroke Center include the recruitment of a neurologist which can assist in meeting the needs of this community. Alzheimer's disease is ranked as the sixth leading cause of death in the United States.[1] Alzheimer's disease is currently diagnosed in approximately 5.4 million Americans and the American Alzheimer's association projects the number will triple to 16 million by the year 2050.[2] Parkinson's disease affects 1 million Americans, with at least 60,000 new cases reported annually. According to a global study conducted by the World Health Organization, 8 out of 10 disorders in the 3 highest disability classes are neurologic problems.[3]

The risk factors associated with stroke and neurological disorders include age, gender, ethnicity and behavioral characteristics. The demographics of the area covered by TRMC is considered high risk for these disorders and the forecasted growth in our area increases these concerns.

Stroke risk increases with age. For each decade after age 55, the risk of stroke doubles. The current population of TRMC area is approximately 31% over the age of 50. Projections for the 5 year growth of this area shows the 50+ demographics with the highest % of growth with a 12.7% increase in population. Women account for approximately 43 percent of strokes that occur each year but they account for 61 percent of stroke deaths. Women comprise 53% of the TRMC area.

Race also impacts the risk of stroke. The 2010 Census data for Titus County demographics were 48.2% Caucasian, 40.6% Hispanic and 10.1% African American. In African-American females, the incidence is 79 per 100,000, with a death rate of 39.2 percent. Young African-Americans have a two to three times greater risk of ischemic stroke than the Caucasian population of the same age. The incidence rate of stroke in Caucasian males is 62.8 per 100,000, with a 26.3 percent death rate. In Caucasian females, the incidence is 59 per 100,000, with a death rate of 39.2 percent. The estimated age-adjusted prevalence of stroke for Americans aged 20 years and older is 2.2 percent for non-Hispanic white men and 1.5 percent for women; for non-Hispanic blacks, 2.5 percent for men and 3.2 percent for women; and for Mexican Americans, 2.3 percent for men and 1.3 percent for women.

Behavioral choices impact the occurrence of strokes. Cardiac heart failure (CHF) causes 75,000 strokes per year in the United States. People with uncontrolled high blood pressure are seven times more likely to have a stroke than people with controlled high blood pressure. The risk of stroke is two-and-a-half times higher in people with diabetes. The TRMC area was 10.4% above the national average for hypertension, 12.0% above the national average for obesity, 21.7% above the national average for diabetes, 13.5% above the national average for high cholesterol and 11.3% above the national average for physical inactivity.

Education and awareness of the community also play a vital role in the care and treatment of stroke and neurological disorders. More than 75 percent of Americans cannot name the most common warning sign of stroke — sudden numbness or weakness of the face, arm or leg, especially on one side of the body — according to the American Stroke Association. Fewer than half of all individuals over 50 are actually aware of what stroke is, its signs and symptoms, and the importance of seeking immediate medical attention.

The total cost of strokes in the United States is estimated at $43 billion per year. The direct costs of medical care and therapy are estimated at $28 billion per year with the remaining amount as a result of lost productivity and other factors.

The meeting of the requirements of a Level II Primary Stroke Center and the recruitment of a neurologist to our area will have an exponential impact to our community.

Related Category 3 Outcome Measures:
Through implementation of the processes to achieve Level II Primary Stroke Center and access to neurologist (138913209.1.3), the Stroke (CVA) 30 day readmission rate will be decreased. This measure estimates the hospital-level, risk-standardized rate of unplanned, Stroke (CVA) readmissions after admission for Stroke (CVA) within 30 days of hospital discharge for patients aged 18 and older (138913209.3.6). This was chosen as the outcome measure because it is closely aligned with the purpose of this Category 1 project.

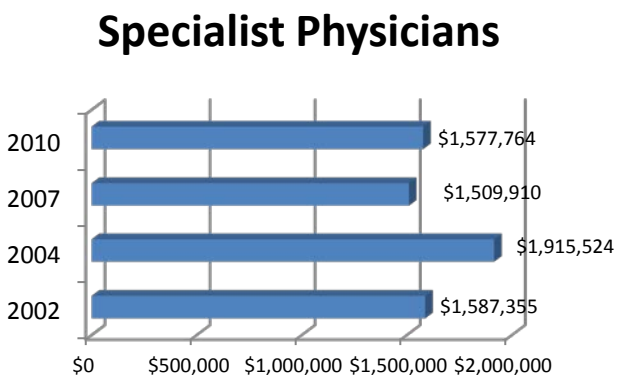
TRMC has selected OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs). IT-3.7: Stroke (CVA) 30 day readmission rate.

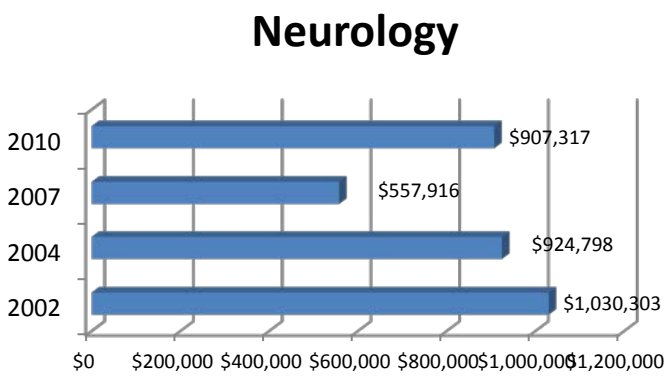
TRMC plans to engage in project planning during DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for the percentage. TRMC plans to reduce readmission rates by 5% and 10% to baseline in demonstration years 4 and 5, respectively.

Relationships to Other Performing Provider Projects in the RHP:
TRMC has ensured that all project plans fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative:
TRMC intends to participate and lead some of the learning collaborative opportunities to share best practices. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation:
Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a specialist physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional specialist.





The 2011 Medical Group Management Association published Physician Gross Charges (TC/NPP Excluded) in their "Physician Compensation and Production Survey: 2011 Report based on 2010 Data" for the 75th percentile for Neurology at $1,012,165.

Per the most recent spending report from the Center for Medicare and Medicaid Studies (CMS), the cost of care in the first 30 days following a stroke is estimated at $13,000 in mild cases and $20,000 in severe cases with the lifetime cost of a stroke approximately $140,000. The bulk of those costs comes in the form of chronic care and rehabilitation. Over a 4-year period in 1996, a study of 414 Medicare patients demonstrated a steady decline of initial hospital length of stay from 7.0 to 4.6 days due to the presence of stroke support team. During this same period of time, there was a decline in total hospital charges from $14,076 to $10,740 per patient. This study projected a cost savings of about $3,300 per discharge. Assuming an estimated 150 stroke patients at TRMC projects an estimated cost savings of approximately $495,000 per year.

The charts and data above value Neurology at $960,000 per year and cost of savings of approximately $495,000 per year. Accordingly, TRMC's average DSRIP funding request of approximately $981,250 per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

[1]National Center for Health Statistics. Available at: *www.cdc.gov/nchs/fastats/deaths.htm*
[2] 2011 Alzheimer's disease Facts and Figures (online). Available at: *www.alz.org/downloads/Facts_Figures_2011.pdf*. Accessed May 12, 2011.
[3] Menken M. The Global Burden of Disease Study. Implications for Neurology. *Archives of Neurology* 2000;57:418-420.

138913209.1.3	*1.9.1*	*1.9.1*	**1.9 - Expand Specialty Care Capacity**	
Titus Regional Medical Center				138913209
Related Category 3 Outcome Measure(s):	138913209.3.6	*IT – 3.7*	Stroke (CVA) 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: 1.9.1. P-1: Conduct specialty care gap assessment based on community need. **Metric: 1.9.1. P-1.1** Documentation of gap assessment of Level II Primary Stroke Center. **Data Source:** Needs assessment. **Milestone 1 Estimated Incentive Payment: $369,054** **Milestone 2: 1.9.1. P-2.1**: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. **Metric: 1.9.1. P-2.1** Training of staff and providers on Stroke Center designation responsibilities. **Numerator:** Number of staff and providers trained and documentation of training materials on Stroke Center processes.	**Milestone 3: 1.9.1. I-34**: Achieve designation of Level III Designated Stroke Center. **Metric: 1.9.1. I-34.1** Documentation of Level III Designated Stroke Center with State of Texas. **Baseline/Goal:** Documentation of Level III Designated Stroke Center with State of Texas. **Data Source:** Documentation of designation. **Milestone 3 Estimated Incentive Payment: $422,587.50** **Milestone 4: 1.9.1. P-11**: Launch/expand a specialty care clinic – neurologist **Metric: 1.9.1. P-11.1** Establish/expand specialty clinics. **Baseline/Goal:** Documentation of new/expanded specialty care clinic		**Milestone 5: 1.9.1. I-35**: Achieve designation of Level II Primary Stroke Center. **Metric: 1.9.1. I-35.1** Documentation of Level II Primary Stroke Center with State of Texas. **Baseline/Goal:** Documentation of Level II Primary stroke Center with State of Texas. **Data Source:** Documentation of designation. **Milestone 5 Estimated Incentive Payment: $422,539.50** **Milestone 6: 1.9.1. I-23**: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.1. I-23.1** Documentation of baseline number of visits. **Baseline/Goal:** Establish a baseline for specialty care encounters.	**Milestone 7: 1.9.1. I-23**: Increase specialty care encounters and evidence of improved access for patients seeking services. **Metric: 1.9.2. I-23.1** Documentation of increased number of encounters. Demonstrate improvement over prior reporting period (baseline for DY4). **Baseline/Goal:** 10% increase in encounters over baseline, calculated as (new # - baseline)/baseline Baseline defined as encounters in DY 4. **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 7 Estimated Incentive Payment: $682,744**

138913209.1.3	*1.9.1*	*1.9.1*	**1.9 - Expand Specialty Care Capacity**	
Titus Regional Medical Center				138913209
Related Category 3 Outcome Measure(s):	138913209.3.6	*IT – 3.7*	Stroke (CVA) 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Denominator: Total number of staff and providers on the Stroke Team. **Data Source:** Log of specialty care personnel trained. **Milestone 2 Estimated Incentive Payment*:* $369,054**		**Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment*:* $422,587.50**	**Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 6 Estimated Incentive Payment: $422,539.50**	
Year 2 Estimated Milestone Bundle Amount: $738,108		**Year 3 Estimated Milestone Bundle Amount: $845,175**	**Year 4 Estimated Milestone Bundle Amount: $845,079**	**Year 5 Estimated Milestone Bundle Amount: $682,744**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $3,111,106				

Project Option: 1.1.1 - Establish more primary care clinics
Unique Project ID Number: 139173209.1.1 (PASS 1)
Performing Provider Name/TPI: ETMC Athens 139173209

Project Abstract

Provider: East Texas Medical Center Athens (ETMC) is a 117-bed, full-service hospital dedicated to serving the Henderson County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Henderson County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 258,782.

Intervention: This project increases access to healthcare through establishing a new primary care clinic on the ETMC Athens campus. This project is not duplicative of 139173209.1.2 – Expand Primary Care Capacity, as these clinics are at separate locations and serving different target populations.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Western Region (Freestone, Henderson, Kaufman, and Van Zandt Counties) that currently do not have sufficient access to primary care. We expect to serve an average of 2592 new clinic patients with a Medicaid and indigent share of 30%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 12% increase in primary care encounters over baseline by DY 5, an estimated 2,688 patients. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 2% in DY 4 and 4% in DY 5.

Project Narrative

Project Description: ETMC Athens's goal is to expand patient access to primary care where they can receive preventive and proactive care, more efficiently. The four-year target goal is to improve patient access through a new ETMC primary care clinic, as evidenced by a 12% increase in primary care encounters over baseline.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC Athens is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC Athens is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

We propose to enhance primary care service availability by establishing a new primary care clinic at ETMC Athens. Coverage for the new clinic will be provided through a contract with Lakeland Medical Associates—an established primary care practice in Athens. While Lakeland Medical Associates has a large presence in the Athens community, there is still a need for expanded services in the area. The clinic space is on the hospital's main campus and will require renovations in year 2 to properly operate as a clinic.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services in the ETMC Western Region. In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Service Area Population 258,782						
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)				PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7	29.5	76	62	(14)
Geriatric Medicine	0	0	2.6	7	2	(5)
Internal Medicine	28.8	17.6	23.2	60	11	(49)
Pediatrics	12.8	12.9	12.9	33	8	(25)
Primary Care Total				**176**	**83**	(93)

*2011 Texas Medical Board database

Establishing a new clinic will expand service availability to those not currently utilizing primary care services, provide better options for the employed population, and help accommodate volume shift due to ED triage protocol. Operating a clinic on the hospital campus is another step towards offering a full continuum of services to the Athens community; and partnering with established community physicians will aid in expanding service availability.

Since we are establishing a new clinic, there is no baseline of clinic volume; however, we are starting with available clinic space on the ETMC Athens campus. This space will be renovated to accommodate the new clinic and expand primary care access to the Athens community.

Rationale: While there several options for primary care in the Athens community, there is not currently a clinic on the ETMC Athens campus. Lakeland Medical Associates is one of the largest primary care providers in the area and wants to expand services to the hospital campus. The current lack of available appointment times and clinics in Athens leads to long waiting times and an underserved population.

The significance of expanding primary care availability through a new physician clinic is seen by the increasing number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), a new clinic with more appointment availability will allow patients to come at their convenience and have better access to primary care. A clinic on the hospital campus will provide a central location for patients to access primary care. In addition, easily transferring non-urgent ED patients to the onsite clinic will quickly and conveniently meet their needs. Increased access to primary care will inherently build better habits for patients to seek primary care rather than emergency care. Furthermore, the relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans.

Patients seeking primary care in the ED will need a place to be seen after ETMC's ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National

Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 2% in DY 4 and 4% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Providing a new clinic will promote higher quality healthcare to our patients at an overall lower cost to payers, and will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how creating a new primary care clinic will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (139173209.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. ETMC Athens will establish a new primary care on the campus (139173209.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

In addition to the newly established Athens clinic, there is also a need for primary care physicians in the area. We plan to recruit 4 primary care physicians which will be (139173209.1.2) to increase the overall access to primary care throughout the Athens community.

The combination of these primary care projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for

ambulatory care sensitive conditions under age 75 years (139173209.3.1-3) due to enhanced physician-patient relationships and preventive care.

Moreover, expanding care transitions programs (139173209.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will improve outcomes and decrease 30 day readmissions (139173209.3.4). Redesigning to improve the patient experience (139173209.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction (139173209.3.5). We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots." After applying this decreased utilization data, the chart below values the new clinic over $1.1M per year. Accordingly, ETMC's average DSRIP funding request of approximately $962,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings New Primary Care Clinic		
Total New Clinic Patients		4,000
ED visits / year / person		0.45
Potential ED Visits		1,804
ED Visits Reduced @ 15%		271
Avg ED Payment		$425
ED Savings	**$**	**115,005**
IP Admissions / year / person		0.11
Potential IP Admissions		456
Admissions Reduced @ 18%		82
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**1,013,661**
Total Estimated Savings	**$**	**1,128,666**

139173209.1.1	***1.1.1***	***1.1.1***	***Expand Primary Care Capacity***
ETMC Athens			*139173209*
Related Category 3 Outcome Measure(s):	***139173209.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-1 Establish additional/expand existing/relocate primary care clinics. **Metric: 1.1.1.P-1** Number of additional clinics or expanded hours or space **Baseline/Goal:** Documentation of detailed expansion plans **Data Source**: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider **Milestone 1 Estimated Incentive Payment:** $757,396	**Milestone 2: 1.1.1.I-12** Establish a baseline of primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.1.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Establish a baseline of primary care clinic volume of visits. ETMC Athens estimates this to be 2,400 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $826,278	**Milestone 3: 1.1.1.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.1.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 8% [192] out of a baseline of 2,400 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $828,680	**Milestone 4: 1.1.1.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.1.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 12% [288] out of a baseline of 2,400. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $684,562
Year 2 Estimated Total DSRIP: $757,396	Year 3 Estimated Total DSRIP: $826,278	Year 4 Estimated Total DSRIP: $828,680	Year 5 Estimated Total DSRIP: $684,562
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$3,096,915***			

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 139173209.1.2 (PASS 1)
Performing Provider Name/TPI: ETMC Athens 139173209

Project Abstract

Provider: East Texas Medical Center Athens (ETMC) is a 117-bed, full-service hospital dedicated to serving the Henderson County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Henderson County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 258,782.

Intervention: This project increases access to healthcare through recruiting four primary care providers adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Western Region (Freestone, Henderson, Kaufman, and Van Zandt Counties) that currently do not have sufficient access to primary care. We expect to serve an average of 9,400 new clinic patients with a Medicaid and indigent share of 30%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 50% increase in primary care encounters over baseline by DY 5, an estimated 11,280 patients. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 2% in DY 4 and 4% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by recruiting four primary care providers. The DY 5 goal is to improve ETMC's primary care capacity, as evidenced by a 50% increase in primary care encounters over baseline.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC Athens is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC Athens is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, expanding the clinic staffing and hours will be necessary to cover additional patients. Staffing expansion will include four primary care providers and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services and pediatrics. The ETMC Western Region is currently underserved by 93 primary care physicians—including a shortage of 25 pediatricians.

Service Area Population 258,782						
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)				PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7	29.5	76	62	(14)
Geriatric Medicine	0	0	2.6	7	2	(5)
Internal Medicine	28.8	17.6	23.2	60	11	(49)
Pediatrics	12.8	12.9	12.9	33	8	(25)
Primary Care Total				**176**	**83**	**(93)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Patients seeking primary care in the ED will need a place to be seen after ETMC's ED patient navigation and triage protocol redirects them to a clinic. Since 67% of ED visits arrive on weekends or after office hours, the extended hours are necessary to meet the demand. In addition, patients redirected from the ED will likely utilize the primary care clinic more frequently than the ED. According to national utilization rates from the 2009 National Ambulatory Medical Care Survey, there are 45.1 ED visits per 100 people per year; while there are 194.6 primary care office visits per 100 people per year.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 2% in DY 4 and 4% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional primary care

providers will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how increasing clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (139173209.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. ETMC Athens will establish a new primary care on the campus (139173209.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

In addition to the newly established Athens clinic, there is also a need for primary care physicians in the area. We plan to recruit 4 primary care physicians which will be (139173209.1.2) to increase the overall access to primary care throughout the Athens community.

The combination of these primary care projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (139173209.3.1-3) due to enhanced physician-patient relationships and preventive care.

Moreover, expanding care transitions programs (139173209.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will improve outcomes and decrease 30 day readmissions (139173209.3.4). Redesigning to improve the patient experience (139173209.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction (139173209.3.5). We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

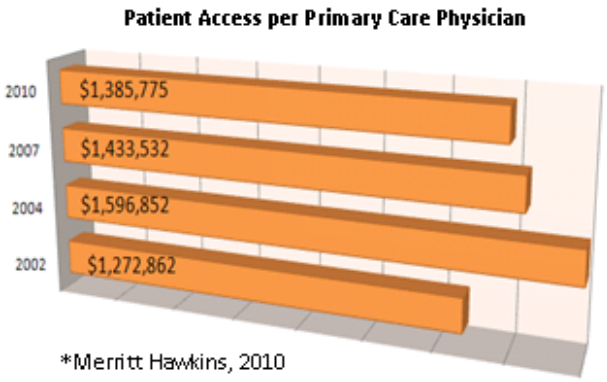
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

Applying the decreased utilization data values the savings at $2.2M and the physician impact on access is valued at $1.3M per physician. Accordingly, ETMC's average DSRIP funding request of approximately $2M per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Primary Care Staffing	
Estimated Patients Served	8,000
ED visits / year / person	0.45
ED Visits	3,608
Prevented ED Visits @ 15% Reduction	**541**
ED Cost per Patient	$ 425
ED Savings	**$ 230,010**
IP Admissions / year / person	0.11
Inpatient Admissions	912
Prevented Admissions @ 18% Reduction	**164**
Avg Total Medicare Cost / Discharge	$12,354
Inpatient Savings	**$ 2,027,321**
Total Estimated Savings	**$ 2,257,331**



139173209.1.2	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Athens			*139173209*
Related Category 3 Outcome Measure(s):	***139173209.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-5 Train/hire additional primary care providers and staff and/or increase the number primary care clinics for existing providers. **Metric: 1.1.2.P-5.1** Documentation of increased number of providers and staff and/or clinic sites. **Baseline/Goal:** Increase number of primary care providers. **Data Source**: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation **Milestone 1 Estimated Incentive Payment:** $1,581,916	**Milestone 2: 1.1.2.I-12** Establish baseline primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of baseline number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Establish baseline primary care clinic volume of visits. ETMC Athens estimates this to be 7,520 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $1,725,785	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 25% [1,880] out of a baseline of 7,520 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $1,730,802	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 50% [3,760] out of a baseline of 7,520 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $1,429,793
Year 2 Estimated Total DSRIP: $1,581,916	Year 3 Estimated Total DSRIP: $1,725,785	Year 4 Estimated Total DSRIP: $1,730,802	Year 5 Estimated Total DSRIP: $1,429,793
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$6,468,296***			

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 140425362.1.1 (Pass 1)
Performing Provider Name/TPI: Paris-Lamar County Health Department 140425362

Project Abstract

Provider Description: The Paris-Lamar County Health Department provides primary health care services in Lamar County, serving a 907.19 square mile area with a population of approximately 50,000.

Intervention: This project will improve primary care service accessibility by expanding primary care clinic space, expand primary care clinic hours, expand primary care providers and staff, expand primary care clinic staff knowledge, and expand urgent care services. The Paris-Lamar County Health Department proposes to extend clinic hours from 9a-4p Monday-Thursday to 7a-6p Monday-Thursday. The primary goal is to increase Paris Lamar County Health Department's primary care capacity by 20% over the 4 year waiver period.

Need for the Project: In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. The motivation behind the expansion of primary care availability at the Paris-Lamar County Health Department is to address community needs assessment (CN.1), insufficient access to primary or specialty care services. Most individuals find it difficult to schedule appointments during regular working hours; therefore, extending clinic hours, clinic staffing, and space will allow individuals to schedule appointments before and after work and have better access to primary care and reduce emergency department usage.
With an estimated cost of $500 to $2000 per emergency room visit, multiplied by the 600-1100 individuals accessing the hospital for non- emergent issues, expanding primary care capacity could yield an approximate savings of between $250,000 and $1.5 million dollars resulting bad debt.

Target Population: The target population is our patients that find it difficult to schedule appointments during regular working hours; therefore, extending clinic hours, clinic staffing, and space will allow individuals to schedule appointments before and after work and have better access to primary care.

Category 1 Expended Patient Benefits: The project seeks to increase primary care clinic volume of visits and evidence of improved access for patients seeking services by 10% or 254 additional visits over baseline of 2,541 visits in DY 3, 15 % or by 381 additional visits in DY 4 & 20% or 508 additional visits in DY 5. Patients will benefit from more appointment availability and expanded access

Category 3 Outcomes: We propose to increase the overall quality of care and improve the health status of our target population, new Paris-Lamar County Health Department primary care clinic patients, by extending clinic hours, recruiting additional staff and expanding clinic space. These necessary changes will promote higher quality healthcare and increased appointment availability to our patients and reduce inappropriate emergency department visits. The previously stated project description and rationale further describes how extending primary care clinic hours, clinic staffing and space will help reduce the amount of patients utilizing the Emergency Department for their primary care needs. By having better access you can decrease inappropriate emergency department visits or readmissions "for some disease states.

The related category 3 outcome measure is IT- 6.1: Percent Improvement over baseline of patient satisfaction scores in Patient Satisfaction Domain (OD-6**)** patients getting timely care, appointments, and information. The Paris-Lamar County Health Department's goal is to increase overall patient satisfaction by 10% over baseline, each year, over the waiver period regarding getting timely care, appointments and information.

Project Narrative

Project Description: The goal of the Paris-Lamar County Health Department is to expand the capacity of preventive and primary care services to better accommodate the needs of the patient population and community so that patients can receive the right care at the right time in the right setting. We propose to improve primary care service accessibility by expanding primary care clinic space, expand primary care clinic hours, expand primary care providers and staff, expand primary care clinic staff knowledge, and expand urgent care services. The Paris-Lamar County Health Department proposes to extend clinic hours from 9a-4p Monday-Thursday to 7a-6p Monday-Thursday, adding an additional 8 hours of clinic time each week. . The primary goal is to increase PLCHD's primary care capacity by 20% over the 4 year waiver period.

The Health Department recognizes that there is a large underserved population of persons in profound need of primary health care services. This is due to extreme poverty, lack of education, and resources. It is the vision and desire of the PLCHD to reach out and serve this population in need of quality health care services. We expect to obtain this solution by expanding the current delivery system (e.g., personnel, space, hours, access, and other resources necessary to reach the underserved population).

Starting Point/Baseline: Extending clinic hours, staff, and space will allow for increased access and availability for individuals not currently utilizing primary care services. The Paris-Lamar County Health Department saw a baseline of 2,541 visits in FY2012 while seeing patients Monday-Thursday 9a-4p.

Rationale: In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and

a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services. The motivation behind the expansion of primary care availability at the Paris-Lamar County Health Department is to address community needs assessment (CN.1), insufficient access to primary or specialty care services. Most individuals find it difficult to schedule appointments during regular working hours; therefore, extending clinic hours, clinic staffing, and space will allow individuals to schedule appointments before and after work and have better access to primary care. One of the major issues facing Lamar County is the amount of individuals that access the emergency room for their primary care needs. Paris Regional Medical Center is currently treating approximately 600-1100 individuals monthly for non-emergent issues, of which approximately 85% results in bad debt. One main objective of expanding primary care services at the Paris-Lamar County Health Department is to reduce the amount of patients utilizing the Emergency Department for their primary care needs. With an estimated cost of $500 to $2000 per emergency room visit, multiplied by the 600-1100 individuals accessing the hospital for non- emergent issues, expanding primary care capacity could yield an approximate savings of between $250,000 and $1.5 million dollars resulting bad debt.

The challenge is to reach out and provide access, to high quality, low cost, primary health care services to the targeted, underserved population. The Paris/Lamar County Health Department services a large number of impoverished, uneducated, mentally ill, and otherwise under-resourced individuals. The PLCHD expects to realize an established, high quality, low cost, delivery health care system that provides increased access to a greater number of persons from the underserved population. The challenge is to meet this need and to reduce the amount of individuals accessing the emergency room for non emergent issues.

According to the U.S Census Bureau 2010 demographic profile data, Lamar County has a total population of 49,793 with 24,044 male and 25,749 female, 39,489 white, 6,703 black or African American, 3,223 Hispanic or Latino, 700 American Indian or Alaska Native and 311 Asian.

Median Age consists of 20,507 16 years and over, 19,828, 18 years and over, 18,731 21 years and over, 5,580, 62 years and over and 4,693 65 years and over. Eighty percent of Lamar County has graduated from high school and over twenty five percent have a bachelor's degree or higher. **Lamar County**		**Margin of Error**	**Texas**	**Margin of Error**
Percent high school graduate or higher	80.0%	+/-0.1	82.4%	+/-1.6
Percent bachelor's degree or higher	25.8%	+/-0.1	17.4%	+/-1.4

Percentage of families and people in Lamar County whose income in the past 12 months is below the poverty level is 12.4% with an unemployment rate of 3.7%. 13,767 families are currently receiving Food Stamp/SNAP benefits. There are 10,038 people, 20.4% of Lamar County's population that have no health insurance coverage.

Income & Poverty

Table X. Median, Mean, & Per capita Income in Lamar County & Texas56 Lamar		**Margin of Error**	**Texas**	**Margin of Error**
Median family income	$ 49,256.00	+/-2,870	$ 58,142.00	+/-235
Mean family income	$ 60,972.00	+/-2,590	$ 78,037.00	+/-260
Per capita income	$ 20,588.00	+/-766	$ 24,870.00	+/-82

56 U.S. Census Bureau. Selected

	Lamar County	**Margin of Error**	**Texas**	**Margin of Error**
All families	12.4%	+/-1.8	13.0%	+/-0.1
With related children < 18 years	18.1%	+/-3.1	19.1%	+/-0.2
With related children < 5 years	34.4%	+/-9.8	19.5%	+/-0.4
Married couple families	6.9%	+/-1.4	7.4%	+/-0.1
Families w/ female householder, no husband present	35.4%	+/-7.0	32.8%	+/-0.3
All people	16.7%	+/-1.8	16.8%	+/-0.1
Under 18 years	22.8%	+/-3.6	23.8%	+/-0.3
18 years and over	14.7%	+/-1.6	14.0%	+/-0.1
18 to 64 years	15.2%	+/-1.9	14.4%	+/-0.1
65 years and over	12.8%	+/-2.3	11.6%	+/-0.2

Lamar County has one major medical center (Paris Regional Medical Center), one mental health facility (Lakes Regional MHMR, and one minor emergency center (Salas Minor Emergency).

According to the U.S. Census Bureau and the CDC, some key health challenges specific to North East Texas and Lamar County in particular are diabetes, obesity and heart disease and stroke related deaths. According to the Texas Department of State Health Services, heart disease and stroke are of particular concern in Upper East Texas, where mortality rates from heart disease are among the highest in the state.

Diabetes Rate %	10.8
Obesity Rate %	25.5
Physical Inactivity Rate %	29.6
Total Diabetes (#people)	3,894
Total Obesity (#people)	9,148

Related Category 3 Outcome Measure: The related category 3 outcome measure is IT- 6.1: Percent Improvement over baseline of patient satisfaction scores in Patient Satisfaction Domain (OD-6**)** patients getting timely care, appointments, and information. The Paris-Lamar County Health Department's goal is to increase overall patient satisfaction by 10% over baseline, each year, over the waiver period regarding getting timely care, appointments and information. We propose to expand the capacity of preventive and primary care services to better accommodate the needs of the patient population and community so that patients can receive the right care at the right time in the right setting.

Relationship to Other Projects:
The PLCHD is currently collaborating with Lamar County Indigent Health Care to provide high quality, low cost access to primary health care services to the severely impoverished populations of the community. In addition, the expansion of primary care services will help alleviate the amount of patients utilizing the emergency department for their primary care.

Relationships to Other Performing Provider Projects in the RHP: The Paris-Lamar County Health Department ensures that the proposed project aligns with the community needs and works in conjunction with the RHP initiatives.

Plan For Learning Collaborative: The Paris-Lamar County Health Department plans to engage in RHP learning collaborative that focus on similar primary care expansion projects. Participating in learning collaborative will help to identify specific challenges, identify Best Practices, identify areas for improvement and test new ideas. In addition, participating in the learning collaborative will allow the sharing of ideas and solutions from other providers who are implementing similar projects.

Project Valuation: Shifting non-urgent patients to a primary care clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit. With an estimated cost of $500 to $2000 per emergency room visit, multiplied by the 600-1100 individuals accessing the hospital monthly for non- emergent issues, expanding primary care capacity could yield an approximate savings of between $250,000 and $1.5 million dollars resulting in bad debt.

140425362.1.1	*1.1.2*	*1.1.2A-C*	**Expand Primary Care Capacity**
Paris-Lamar County Health Department		***140425362***	
Related Category 3 Outcome Measure(s):	***140425362.3.1***	***3.1IT-6.1***	***Percent improvement over baseline of patient satisfaction scores***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: 1.1.2. P-1 = Establish additional/expand existing/relocate primary care clinics Metric **: 1.1.2. P-1.1 Number of additional clinics or expanded hours or space** Baseline/Goal:**:** Extending clinic hours, staff, and space beyond current capacity Data Source: Documentation of detailed expansion plans Milestone 1 Estimated Incentive Payment: $356,250.00	**Milestone 2**: **1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric: 1.1.2.I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Increased visits by 10% or 254 additional visits over baseline of 2,541 visits. Data Source: Registry, HER or other Performing Provider source. Milestone 2 Estimated Incentive Payment: $337,500.00	**Milestone 3**: **1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric: 1.1.2.I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Increased visits by 15% or 381 additional visits over baseline of 2,541 visits. Data Source: Registry, HER or other Performing Provider source. Milestone 3 Estimated Incentive Payment: $337,500.00	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric: 1.1.2.I-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: Increased visits by 20% or 508 additional visits over baseline of 2,541 visits. Data Source: Registry, HER or other Performing Provider source. Milestone 3 Estimated Incentive Payment: $300,000.00
Year 2 Estimated Total DSRIP: ***$356,250.00***	Year 3 Estimated Total DSRIP: **$337,500.00**	Year 4 Estimated Total DSRIP: **$337,500.00**	Year 5 Estimated Total DSRIP: **$300,000.00**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $ 1,331,250.00**			

Project Option: 1.1.2 – Expand existing primary care capacity
Unique Project ID Number: 168447401.1.1 (PASS 2)
Performing Provider Name/TPI: ETMC Gilmer 168447401

Project Abstract

Provider: East Texas Medical Center Gilmer (ETMC) is a 37-bed, full-service hospital dedicated to serving the Upshur County area with advanced diagnostics, medical and surgical care, outpatient services, and a Level IV trauma center. ETMC's primary service area is Upshur County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 120,272.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, recruiting a family practice physician and a pediatrician, and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Northern Region (Camp, Franklin, Red River, Wood, and Upshur Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 2,800 new clinic patients with a Medicaid and indigent share of at least 30%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by a 12% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and recruiting a family practice physician and a pediatrician. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The DY 5 target goal is to improve ETMC's primary care capacity, as evidenced by a 12% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include a family practice physician, a pediatrician, and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: ETMC has conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services and pediatrics. The ETMC Northern Region is currently underserved by 33 primary care physicians—including a shortage of 10 pediatricians.

Service Area Population 120,272							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7		29.5	35	33	(2)
Geriatric Medicine	0	0	2.6	2.6	3	1	(2)
Internal Medicine	28.8	17.6		23.2	28	10	(18)
Pediatrics	12.8	12.9		12.9	15	5	(10)
Primary Care Total					**82**	**49**	**(33)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 14,408 visits in FY2012 while operating 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)." Our new physicians will provide additional appointment availability to expand access to primary care.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends and recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and staffing will decrease acute

care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours and clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: The ETMC Gilmer clinic will begin offering extended hours and additional physician staffing (168447401.1.1) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (168447401.3.1) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

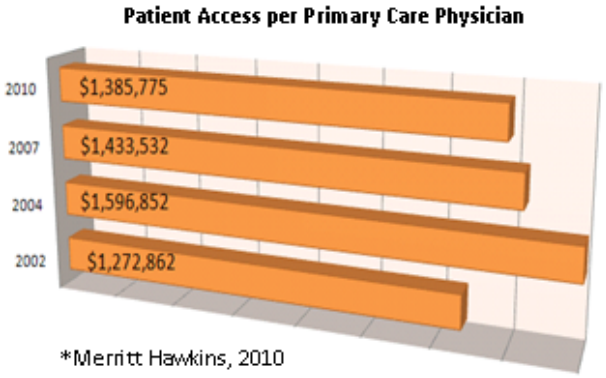
Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $790,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $500,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

The charts below show the annual estimated program savings and access expansion:

Estimated Savings Workforce Enhancement		
Estimated Patients Served		2,800
ED visits / year / person		0.45
ED Visits		1,263
Prevented ED Visits @ 15% Reduction		**189**
ED Cost per Patient	$	425
ED Savings	**$**	**80,504**
IP Admissions / year / person		0.11
Inpatient Admissions		319
Prevented Admissions @ 18% Reduction		**57**
Avg Total Medicare Cost / Discharge		$12,354
Inpatient Savings	**$**	**709,562**
Total Estimated Savings	**$**	**790,066**



168447401.1.1	***1.1.2***	***1.1.2.A-C***	***Expand existing primary care capacity***
ETMC Gilmer			*168447401*
Related Category 3 Outcome Measure(s):	***168447401.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline. **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $379,976	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 4% over baseline of 14,408 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $424,054	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 8% over baseline of 14,408 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $433,277	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 12% over baseline of 14,408 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $360,490
Year 2 Estimated Total DSRIP: $379,976	Year 3 Estimated Total DSRIP: $424,054	Year 4 Estimated Total DSRIP: $433,277	Year 5 Estimated Total DSRIP: $360,490
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,597,797***			

Project Option: 1.1.2 – Expand existing primary care capacity
Unique Project ID Number: 177870603.1.1 (PASS 2)
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Project Abstract

Provider: Red River Regional Hospital (RRRH) is a 25-bed critical access hospital that provides inpatient, outpatient, and emergency services to its communities. RRRH's primary service area is Fannin County, but the secondary service area extends to surrounding communities. The service area population is estimated at around 33,915.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends, recruiting a family practice physician and a physician assistant, and adding needed support staff.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is service area residents that currently do not have sufficient access to primary care. We expect to serve an average of 2,442 new clinic patients with a Medicaid and indigent share of at least 15%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by 2972 primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: Red River Regional Hospital's (RRRH) goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and recruiting a family practice physician and a physician's assistant. RRRH proposes to extend clinic hours to 8a-8p Monday-Thursday, 8a-4p Friday, and 8a-Noon Saturday. The DY 5 target goal is to improve RRRH's primary care capacity, as evidenced by 2972 primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions

are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, RRRH is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of RRRH. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, RRRH is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, RRRH will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include a family practice physician, a physician's assistant, and needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: RRRH has conducted a study of physician needs by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for primary care services. Fannin County is currently underserved by 10 primary care physicians—including a shortage of 5 family practice physicians.

Service Area Population 33,915						
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)				PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	Blended Ratio	Population	All Physicians*	2012
Family Practice	25.2	33.7	29.5	10	5	(5)
Geriatric Medicine	0	0	2.6	1	-	(1)
Internal Medicine	28.8	17.6	23.2	8	8	0
Pediatrics	12.8	12.9	12.9	4	-	(4)
Primary Care Total				**23**	**13**	(10)

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory

Committee (GMENAC) study uses expert testimony to model physician need based on current physician supply, and whether it is adequate given the population base, growth, and future demand. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand (MGMA, NAHCMS).

Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The RRRH clinic saw a baseline of 622 visits in FY2012 while operating Monday-Thursday 8am-5pm and Friday 8am-12pm.

Rationale: The significance of expanding primary care availability through extended clinic hours and physician staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is most patients utilizing the Emergency Department for their primary care needs. Currently, the ED is the only available option after hours and on weekends. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). RRRH's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new RRRH primary care clinic patients. Extending clinic hours to nights and weekends and recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours and clinic staffing will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: The RRRH clinic will begin offering extended hours and additional physician staffing (177870603.1.1) to provide expanded access to primary care and preventive services. The expansion of access to primary care providers will help patients manage chronic disease and improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (177870603.3.1) due to enhanced physician-patient relationships, preventive care, and chronic disease management.

Providing primary care to more patients through our extended hours and staffing will allow RRRH to make a significant impact in disease management. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2) and decrease the cost of acute inpatient care.

The structured outpatient program (SOP) for geriatric, behavioral health patients will improve the functional status of individuals receiving specialized interventions (177870603.2.3). Providing this outpatient program for geriatric, behavioral health patients will effectively decrease the 30 day readmission rate for the same population (177870603.3.4).

While clinic hours, staffing, and behavioral therapy reduce preventable admissions, redesigning to improve the patient experience (177870603.2.2) will improve overall patient satisfaction for inpatient admissions that could not be prevented. We will increase patient satisfaction scores (177870603.3.3) by implementing a mix of administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: RRRH has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

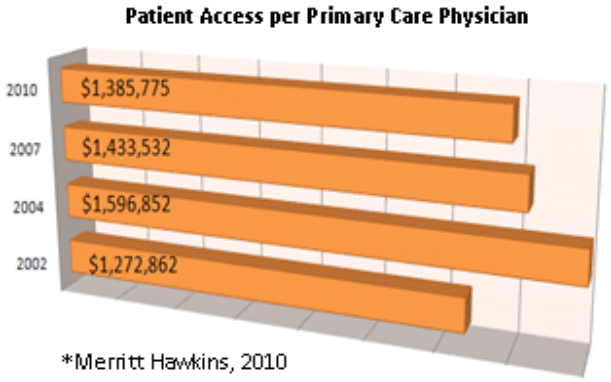
Plan for Learning Collaborative: RRRH plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

The charts below value the access expansion impact of a primary care physician at $1.3M per year and decreased utilization savings at $.7M per year. Accordingly, RRRH's DSRIP funding request of approximately $684,000 per year (including Category 1 and 3) is targeted to be less than the total savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Primary Care Capacity		
Total New Clinic Patients		2,442
ED visits / year / person		0.45
Potential ED Visits		1,101
ED Visits Reduced @ 15%		165
Avg ED Payment		$425
ED Savings	**$**	**70,197**
IP Admissions / year / person		0.11
Potential IP Admissions		278
Admissions Reduced @ 18%		50
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**618,717**
Total Estimated Savings	**$**	**688,913**



177870603.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
Red River Regional Hospital			***177870603***
Related Category 3 Outcome Measure(s):	***177870603.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-1 Establish additional/expand existing/relocate primary care clinics. **Metric: 1.1.2.P-1.1** Number of additional clinics or expanded hours or space. **Baseline/Goal:** Documentation of detailed expansion plans to expand existing clinic hours. **Data Source**: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. **Milestone 1 Estimated Incentive Payment:** $522,444	**Milestone 1: 1.1.2.P-4** Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline. **Baseline/Goal:** Establish a baseline for primary care clinic volume. Baseline of current clinic volume is 622 visits. **Data Source**: Clinic Documentation **Milestone 2 Estimated Incentive Payment:** $583,047	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 1880 over baseline of 622 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $595,728	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 2350 over baseline of 622 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $495,651
Year 2 Estimated Total DSRIP: $522,444	Year 3 Estimated Total DSRIP: $583,047	Year 4 Estimated Total DSRIP: $595,728	Year 5 Estimated Total DSRIP: $495,651
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$2,196,871***			

Project Option: 1.1.2 – Expand existing primary care capacity.
Unique Project ID Number: 208843701.1.1 (PASS 1)
Performing Provider Name/TPI: ETMC Henderson 208843701

Project Abstract

Provider: East Texas Medical Center Henderson (ETMC) is a 49-bed, full-service hospital dedicated to serving the Rusk County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Rusk County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 242,000.

Intervention: This project increases access to healthcare through extended clinic hours on nights and weekends and adding needed physician and support hours.

Need for the Project: As sited in the community needs assessment (CN.1 and CN.3), there is a critical shortage of primary care capacity and access to chronic disease management. More appointment availability will give patients better access to preventive, primary care.

Target Population: The target population is residents of ETMC's Southeastern Region (Cherokee, Gregg, Panola, and Rusk Counties) that currently do not have sufficient access to primary care. We expect to serve approximately 833 new clinic patients with a Medicaid and indigent share of at least 35%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's primary care capacity, as evidenced by an 8% increase in primary care encounters by DY 5. Patients will benefit from more appointment availability and expanded access.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: ETMC's goal is to be able to treat more patients in the primary care setting where they can receive more preventive and proactive care, more efficiently. We propose to enhance primary care service availability by offering extended clinic hours and staffing. ETMC proposes to extend clinic hours to 8a-8p Monday-Friday and 8a-Noon Saturday. The four-year target goal is to improve ETMC's primary care capacity, as evidenced by an 8% increase in primary care encounters.

East Texas communities have a growing share of people with multiple chronic conditions and various other challenges with access to care. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling and long waiting times have a significant negative impact on patient and provider satisfaction and quality of care and discourage people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

As part of our plan to expand existing primary care capacity, ETMC will extend clinic hours to include nights and weekends. Expanding the clinic staffing will be necessary to cover the additional hours and patients. Staffing expansion will include additional physician hours as well as needed nursing/clerical hours. Currently, there is no need for additional clinic space, but we will consider expanding space capacity if the patient demand permits.

Starting Point/Baseline: Offering extended clinic hours and physician staffing will expand service availability to those not currently utilizing primary care services. The ETMC clinic saw a baseline of 12,772 visits in FY2012 while seeing patients 8a-5p Monday-Friday.

Rationale: The significance of expanding primary care availability through extended clinic hours and staffing is seen by increasing the number of primary care clinic visits, translating to a healthier population and decreased hospital utilization. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to primary care. The relationships built with the primary care physicians will promote healthier lifestyles, improve chronic disease management, and facilitate effective follow up care with treatment plans. In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

It is also difficult for working patients to schedule appointments during normal business hours, and the result is a large percentage of patients utilizing the Emergency Department for their

primary care needs. An article published in Health Affairs, a peer-review healthcare journal, suggests that "two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent)."

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Extending clinic hours to nights and weekends will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased hours and clinic staffing will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how extending primary care clinic hours will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: The ETMC Henderson clinic will begin offering extended hours (208843701.1.1) to expand overall access to primary care in Rusk County and beyond. The shortage of primary care providers creates a need for more primary care capacity and access that extended clinic hours will help alleviate.

In addition to a primary care need, there is also great need for a general surgeon in the Henderson area. Recruitment of a general surgeon (208843701.1.2) will expand specialty access to those that have untreated general surgery needs and improve the overall health of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access through extended clinic hours will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years due to enhanced physician-patient relationships and preventive care (208843701.3.1) while a local general surgeon will expand specialty access and decrease surgical site infections (SSI) rates (208843701.3.2).

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate

services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

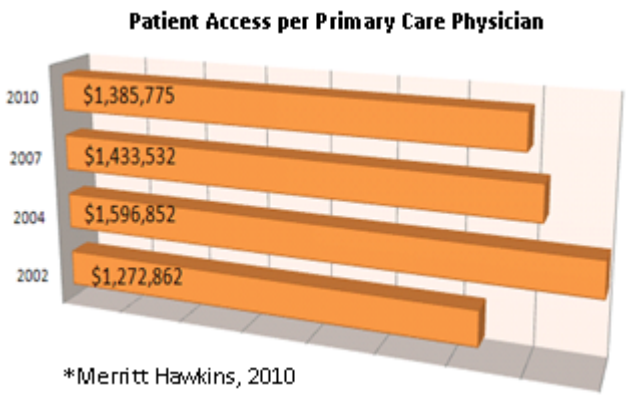
Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $234,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $160,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		833
ED visits / year / person		0.45
Potential ED Visits		376
ED Visits Reduced @ 15%		56
Avg ED Payment		$425
ED Savings	**$**	**23,945**
IP Admissions / year / person		0.11
Potential IP Admissions		95
Admissions Reduced @ 18%		17
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**211,051**
Total Estimated Savings	**$**	**234,995**



208843701.1.1	***1.1.2***	***1.1.2.A-C***	***Expand Primary Care Capacity***
ETMC Henderson			*208843701*
Related Category 3 Outcome Measure(s):	***208843701.3.1***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.1.2.P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric: 1.1.2.P-4.1** Increased number of hours at primary care clinic over baseline **Baseline/Goal:** Expand available clinic hours beyond current capacity. **Data Source**: Clinic Documentation **Milestone 1 Estimated Incentive Payment:** $126,006	**Milestone 2: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 4% over baseline of 12,772 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $137,465	**Milestone 3: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 6% over baseline of 12,772 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $137,865	**Milestone 4: 1.1.2.I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.1.2.I-12.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Increase visits by 8% over baseline of 12,772 visits. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $113,889
Year 2 Estimated Total DSRIP: $126,006	Year 3 Estimated Total DSRIP: $137,465	Year 4 Estimated Total DSRIP: $137,865	Year 5 Estimated Total DSRIP: $113,889
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$515,225***			

Project Option: 1.9.2 – Improve access to specialty care.
Unique Project ID Number: 208843701.1.2 (PASS 1)
Performing Provider Name/TPI: ETMC Henderson 208843701

Project Abstract

Provider: East Texas Medical Center Henderson (ETMC) is a 49-bed, full-service hospital dedicated to serving the Rusk County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Rusk County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 242,000.

Intervention: This project increases access to specialty healthcare through recruiting a full-time general surgeon to establish a specialty clinic location.

Need for the Project: As sited in the community needs assessment (CN.1, CN.4, and CN.5), our region has insufficient access to specialty care services, high costs due to potentially preventable hospitalizations, and inappropriate emergency room utilization. A general surgeon will give patients better access to specialty care.

Target Population: The target population is residents of ETMC's Southeastern Region (Cherokee, Gregg, Panola, and Rusk Counties) that currently do not have sufficient access to specialty or general surgery care. We expect to serve approximately 800 new clinic patients per year with a Medicaid and indigent share of 20%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve ETMC's specialty care capacity, as evidenced by a 12% increase in general surgery clinic visits over baseline by DY 5. Patients will benefit from more appointment availability and expanded specialty access.

Category 3 Outcomes: The related category 3 outcome measure is surgical site infection (SSI) rate (IT-4.4) in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC plans to decrease the surgical site infection (SSI) rate —for general surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: ETMC Henderson's goal is to be able to treat more patients in the specialty care setting where they can receive more appropriate and proactive care, more efficiently. ETMC Henderson plans to expand its specialty care access to providers by recruiting a full-time general surgeon to establish a specialty clinic location. The four-year goal is to see a 12% increase in general surgery clinic visits over baseline.

Historically, resources for specialty services have been extremely limited in the Henderson community. There is an imbalance of demand and supply of specialty services due to a shortage of providers in several medical specialties, creating excessive scheduling delays. Under these circumstances, Henderson residents have been forced to travel to surrounding areas for their specialty care needs. Without regular access to specialty services, conditions are likely to become acute episodes, putting patients at risk for disability and inpatient admissions. The lack of specialty providers has a significant negative impact on patient satisfaction and quality of care and discourages people from using health care proactively.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary and specialty care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand specialty care capacity. Expanding specialty care access meets several community needs outlined by RHP 1, including: insufficient access to specialty care services (CN.1), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

The new general surgery clinic location will increase service availability in the Henderson community. In order to maximize efficiency and specialty care access, the clinic will strive to standardize its referrals across the system and conduct quality improvement activities to identify project impacts and opportunities to scale the project to a broader patient population.

Starting Point/Baseline: ETMC conducted a study of physician needs by region by specialty to pinpoint a recruitment focus on underserved areas. This study shows a great need for surgical specialties in several markets; specifically, the ETMC Southeastern Region is currently underserved by 17 surgical specialists—including 13 general surgeons. Patients must travel to Tyler or other larger cities to have access to a general surgeon or to receive basic preventive procedures such as a screening colonoscopy. As a part of the Southeastern Region, ETMC Henderson plans to recruit a general surgeon to provide specialty coverage.

Service Area Population 242,017							
PHYSICIAN NEED RATIO (PER 100,000 POPULATION)					PHYSICIAN DEMAND	PHYSICIAN SUPPLY	PHYSICIAN NEED
PHYSICIAN SPECIALTY	GMENAC	Hicks & Glenn	DGA Hybrid	Blended Ratio	Population	All Physicians*	2012
General Surgery	9.7	13.6		11.7	28	15	(13)
OB/GYN	9.9	11.1		10.5	25	28	2
Orthopedic Surgery	6.2	5.4		5.8	14	11	(3)
Urology	3.2	2.9		3.1	7	5	(3)
Surgical Specialties					**75**	**58**	**(17)**

*2011 Texas Medical Board database

In order to estimate the physician need, we used a blended ratio based upon an average of the GMENAC and Hicks & Glenn studies. The Graduate Medical Education National Advisory Committee (GMENAC) study uses expert testimony and data to model physician need based on current physician supply by specialty, and whether it is adequate given the population base, growth, and future demand. It is a collaborative approach by a range of experts that utilizes comprehensive data sources. The Hicks & Glenn study is largely a productivity model based on demand for service and the capacity of the respective specialty to serve that demand. This methodology is ideal for projecting needs and uses well regarded source data (MGMA, NAHCMS).

Rationale: Expansion of specialty care is a prerequisite for system-wide improvement, and will have a ripple effect throughout the system. With expanded specialty care access, more patients will have the opportunity to treat episodes early, maintain follow up care, and prevent future hospital stays. Since ETMC Henderson currently does not have a general surgeon and patients must travel for their care, this project represents a new initiative for the performing provider.

Waiting months and/or traveling for a specialty appointment is both frustrating and dangerous: patients and referring physicians are dissatisfied, and the delays in diagnosis and treatment risk preventable patient harm. As sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to specialty care services. In addition, these issues have less obvious but equally harmful operational consequences: referring physicians must make extreme communication and advocacy efforts to get urgent patients seen, and these patients are then over-booked, which disrupts efficient patient flow and creates further patient waits and dissatisfaction. This project will significantly reduce this system dysfunction for general surgery and provide better access to an underserved area.

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-4.4: Surgical site infections (SSI) rates in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC Henderson's goal is to reduce the number of surgical site infections (SSI) for general surgery cases. ETMC plans to develop and test data systems to measure surgical site infections (SSI) rates during DY 2. We will collect preliminary

data in DY 3 to serve as a baseline for improvement in the surgical site infection (SSI) rate. ETMC plans to decrease the surgical site infection (SSI) rate —for general surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively.

We propose to increase the overall quality of care and improve the health status of our target population—general surgery patients at ETMC Henderson. Recruiting a general surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. A local general surgeon and quality improvement oversight will decrease surgical site infection (SSI) rates, which are directly related high costs due to potentially preventable hospitalizations (CN.4).

Relationship to Other Projects: The ETMC Henderson clinic will begin offering extended hours (208843701.1.1) to expand overall access to primary care in Rusk County and beyond. The shortage of primary care providers creates a need for more primary care capacity and access that extended clinic hours will help alleviate.

In addition to a primary care need, there is also great need for a general surgeon in the Henderson area. Recruitment of a general surgeon (208843701.1.2) will expand specialty access to those that have untreated general surgery needs and improve the overall health of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access through extended clinic hours will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years due to enhanced physician-patient relationships and preventive care (208843701.3.1) while a local general surgeon will expand specialty access and decrease surgical site infections (SSI) rates (208843701.3.2).

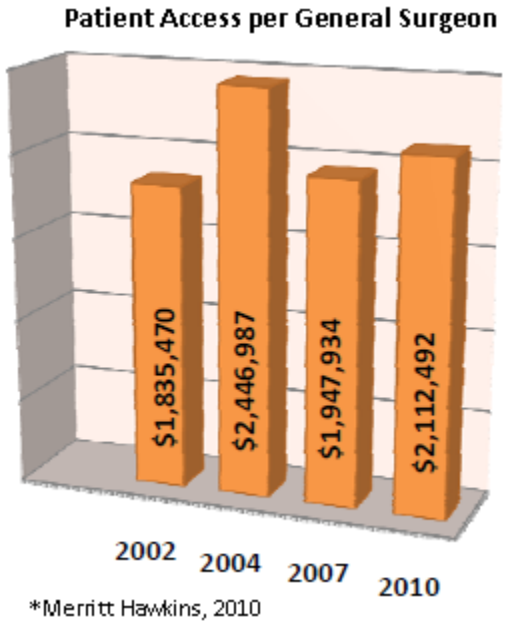
Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on “Physician Inpatient/Outpatient Revenue” that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income

generated by a general surgeon on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional general surgeon.

The chart below values the access expansion of a general surgeon at $2,112,492 per year. Accordingly, ETMC's DSRIP funding request of approximately $700,000 per year (including Category 1 and 3) is targeted to be less than the value of access expansion so that the CMS program accrues a net benefit.



208843701.1.2	***1.9.2***	***1.9.2.A-D***	**Expand Specialty Care Capacity**
ETMC Henderson			***208843701***
Related Category 3 Outcome Measure(s):	***208843701.3.2***	*3.IT-4.4*	***Surgical site infections (SSI) rates***
Year 2	Year 3	Year 4	Year 5
Milestone 1: 1.9.2.P-11 Launch/expand a specialty care clinic—general surgery. **Metric: 1.9.2.P-11.1** Establish/expand specialty care clinics. **Baseline/Goal:** Documentation of new/expanded specialty care clinic **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 1 Estimated Incentive Payment:** $ 504,023	**Milestone 2: 1.9.2.I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of baseline number of visits. **Baseline/Goal:** Establish a baseline for specialty clinic volume. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $ 549,862	**Milestone 3: 1.9.2.I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 8% increase in clinic visits over baseline, calculated as (new # - baseline)/baseline **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $ 551,460	**Milestone 4: 1.9.2.I-23** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric: 1.9.2.I-23.1** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). **Baseline/Goal:** 12% increase in clinic visits over baseline, calculated as (new # - baseline)/baseline **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $ 455,554
Year 2 Estimated Total DSRIP: $504,023	Year 3 Estimated Total DSRIP: $549,862	Year 4 Estimated Total DSRIP: $551,460	Year 5 Estimated Total DSRIP: $455,554
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$2,060,899***			

D. Category 2: Program Innovation and Redesign

Program Innovation and Redesign projects emphasize the piloting, testing, and replicating of innovative care models. Performing Providers participating in Category 2 projects may include hospitals, community mental health centers, local health departments, physician practices affiliated with academic science health centers and physician practices not affiliated with academic health science centers, as defined in Section II of Attachment J (Program Funding and Mechanics Protocol).

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 020812601.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Tyler 020812601

Project Abstract

Provider: East Texas Medical Center Tyler (ETMC) is a 454-bed, regional referral hospital dedicated to serving Northeast Texas with advanced diagnostics, medical and surgical care, obstetrical services, and a Level I trauma center. ETMC's primary service area is Smith County, but the secondary service area extends to 15 Northeast Texas counties. The total service area population is estimated at around 862,894.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of approximately 1,100 new primary care clinic patients each year with a Medicaid and indigent share of 23%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 1,652 patients. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 43,951 emergency room visits in 2012—including 11,017 non-urgent visits (25.1%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Tyler		
Level of Care	**ED Visits**	**Percent**
Unknown	3	0.0%
1 Resuscitation	562	1.3%
2 Emergent	5,542	12.6%
3 Urgent	26,827	61.0%
4 Semi Urgent	8,270	18.8%
5 Non Urgent	2,747	6.3%
Grand Total	**43,951**	**100.0%**
Percent Non-Urgent	11,017	25.1%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care

expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC Tyler plans to implement a Patient Care Navigation Program (020812601.2.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions.

Hiring an endocrinologist (020812601.1.1) provides expansion of services for referred diabetic patients in the ED. The ED triage protocol will create the ability to refer non-urgent patients to the more efficient outpatient clinic setting. Managing the care of diabetic patients will improve health outcomes and decrease the cost of acute inpatient care. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (020812601.1.2) provides expansion of services for referred behavioral health patients in the ED. The ED triage protocol will create the ability to refer non-urgent, behavioral health patients to the more efficient outpatient and partial hospitalization services.

Expanded cardiology coverage (020812601.1.3) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing 30 day readmissions and lowering the cost of cardiac care. Moreover, expanding care transitions programs (020812601.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will also improve outcomes and decrease 30 day readmissions.

Redesigning to improve the patient experience (020812601.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate

services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $1.2M per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		11,017
% Clinic Appropriate		15%
Clinic Appropriate Patients		1,653
Avg ED Facility Payment	$	825
Avg ED Professional Payment	$	248
Estimated ED Savings	**$**	**1,773,186**
Clinic Payment @ 78% savings	$	390,101
Total Estimated Savings	**$**	**1,383,085**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

020812601.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Tyler			*020812601*
Related Category 3 Outcome Measure(s):	***020812601.3.4***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $990,212	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [550] out of a baseline of 11,017 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $1,080,268	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [1,100] out of a baseline of 11,017 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $1,083,408	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 15% [1,652] out of a baseline of 11,017 of non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $894,989
Year 2 Estimated Total DSRIP: $990,212	Year 3 Estimated Total DSRIP: $1,080,268	Year 4 Estimated Total DSRIP: $1,083,408	Year 5 Estimated Total DSRIP: $894,989
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$4,048,877***			

Project Option: 2.12.1 – Develop, implement, and evaluate standardized clinical protocols and evidence based care delivery models to improve care transitions.
Unique Project ID Number: 020812601.2.2 (Pass 1)
Performing Provider Name/TPI: ETMC Tyler 020812601

Project Abstract

Provider: East Texas Medical Center Tyler (ETMC) is a 454-bed, regional referral hospital dedicated to serving Northeast Texas with advanced diagnostics, medical and surgical care, obstetrical services, and a Level I trauma center. ETMC's primary service area is Smith County, but the secondary service area extends to 15 Northeast Texas counties. The total service area population is estimated at around 862,894.

Intervention: This project is to implement the re-engineered discharge (RED) design for congestive heart failure (CHF) patients. Newly established discharge protocol will create smooth transitions of care from inpatient to outpatient settings by providing care management during this time period.

Need for the Project: As sited in the community needs assessment (CN.3, CN.4, and CN.6), our region has high rates of chronic disease, high costs due to potentially preventable hospitalizations, and needs improvement with efficiency in and effectiveness of health care delivery. A delivery model to improve CHF care transitions is needed to ensure progress in these areas.

Target Population: The target population is ETMC Tyler's inpatients with a diagnosis of CHF. We expect to serve approximately 532 CHF patients per year with a Medicaid and indigent share of 23%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve adherence to new CHF care transition processes, evidenced by a 20% increase over baseline by DY 5, an estimated 1,064 patients. Patients will benefit from improved discharge planning and evidence-based, follow-up care.

Category 3 Outcomes: The goal of implementing the re-engineered discharge (RED) design is to reduce potentially preventable readmissions (IT-3.2). The primary outcome measure that will demonstrate our success toward that goal is to decrease the CHF 30 day re-admission rate by 8% over baseline.

Project Narrative

Project Description: Our goal is to reduce potentially preventable readmissions by implementing the re-engineered discharge (RED) design. Focusing on congestive heart failure (CHF) patients, the protocol will create smooth transitions of care from inpatient to outpatient

settings by providing care management during this time period. The four year target goal is to improve adherence to new CHF care transition processes by 20% over baseline (DY 3).

ETMC will create and implement discharge care protocols for CHF patients—much like the AHRQ designed protocol utilized in Project RED. The three core elements of Project RED are the assignment of discharge advocates, the development of a specific after-hospital care plan (AHCP), and follow-up phone calls to the patient's home.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to decrease CHF readmissions through improved discharge planning. Decreasing readmissions meets several community needs outlined by RHP 1, including: high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4) and efficiency in and effectiveness of health care delivery (CN.6).

Our care transitions project will incorporate the required core components, including: review best practices from a range of models; conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool and patient interviews; integrate information systems so that continuity of care for patients is enabled; develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days; implement discharge planning program and post discharge support program; develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers; and conduct quality improvement using by identifying project impacts and "lessons learned."

Starting point/Baseline: While East Texas Medical Center Tyler's case management department educates patients on their discharge planning and medicine reconciliation, there is not a comprehensive process that includes post-discharge phone calls to inquire about their symptoms and to confirm a follow-up clinic appointment. ETMC has explored RED protocol through webinar and seminar attendance and has begun a focus on monitoring readmissions by diagnosis. The case management department has also recently focused on discharge planning improvement and measuring progress through the core measure chart reviews for CHF discharge instructions. When applying national readmission rates, ETMC Tyler has an approximate 532 annual CHF readmissions within 30 days of discharge for FY2012.

Rationale: According to AHRQ, almost one-third of CHF patients are readmitted within 30 days of discharge. A 2010 AHRQ study reports that the average cost of CHF readmission is $13,000 with Medicare expending $880 million annually. Although research suggests that guideline-

based management of heart failure can prevent hospitalizations, AHRQ reports that many hospitals do not consistently follow these guidelines. Patients leave the hospital not understanding why they were admitted, what was done for them in the hospital, and how to care for themselves once released. In particular, patients often leave not knowing what medicines they should and should not be taking, what symptoms to look out for, and who to contact for problems. This lack of knowledge frequently causes patients to be readmitted, causing needless suffering and preventable health care costs.

As sited in the community needs assessment (CN.4), implementing new discharge protocol will decrease the high cost of readmissions for CHF patients. The three core elements of a discharge advocate, the AHCP, and the follow-up phone call will provide patient-centered education, comprehensive discharge planning, and post-discharge reinforcement in a practical and easily applied method. Creating a coordinated transition from inpatient service to home will have multiple benefits to patient experience and safety. With timely and quick post-hospital stay follow-up, problems with understanding and deterioration in clinical health status can be quickly identified and addressed, in most cases over the phone. For patients who have been recently hospitalized, the lack of follow-up appointments and information regarding how to keep themselves healthy puts them at risk for readmission. Reducing expensive and unnecessary readmissions will free resources for care at more appropriate levels.

When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Patients cannot fully participate in their care during and after hospital stays without sufficient understanding of their diagnoses, medication, and self-care needs. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home and community-based services.

Related Category 3 Outcome Measures: The goal of implementing this project is to reduce CHF potentially preventable readmissions (IT-3.2) by implementing the re-engineered discharge (RED) design. Focusing on congestive heart failure (CHF) patients, the protocol will create smooth transitions of care from inpatient to outpatient settings by providing care management during this time period.

The primary outcome measure that will demonstrate our success toward that goal is to decrease the CHF 30 day re-admission rate by 8% over baseline.

Relationship to Other Projects: ETMC Tyler plans to implement a Patient Care Navigation Program (020812601.2.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and

decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions.

Hiring an endocrinologist (020812601.1.1) provides expansion of services for referred diabetic patients in the ED. The ED triage protocol will create the ability to refer non-urgent patients to the more efficient outpatient clinic setting. Managing the care of diabetic patients will improve health outcomes and decrease the cost of acute inpatient care. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (020812601.1.2) provides expansion of services for referred behavioral health patients in the ED. The ED triage protocol will create the ability to refer non-urgent, behavioral health patients to the more efficient outpatient and partial hospitalization services.

Expanded cardiology coverage (020812601.1.3) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing 30 day readmissions and lowering the cost of cardiac care. Moreover, expanding care transitions programs (020812601.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will also improve outcomes and decrease 30 day readmissions.

Redesigning to improve the patient experience (020812601.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A trial study published by the *Annals of Internal Medicine* and the National Institutes of Health on the re-engineered hospital discharge program shows a significant reduction in readmissions and cost. The trial hospital realized a 34% lower total cost of care for the RED intervention group of patients. "The RED intervention [also] decreased hospital utilization (combined emergency department visits and readmissions) within 30 days of discharge by about 30%. More intervention group participants reported seeing their PCP for follow-up within 30 days and reported higher levels of preparedness for discharge. In addition, the intervention was successful in reducing hospital utilization among participants who

frequently used hospital services." The estimated annual cost savings for CHF patients is shown below:

Estimated Savings from CHF Post-Discharge Support	
Annual Cardiac Admissions	1,772
% CHF Readmissions*	30%
CHF Readmissions	532
Cost per CHF Readmission*	$ 13,000
Cost of CHF Readmissions	**$ 6,910,800**
% Decrease in Readmissions	10%
Prevented Readmissions	53
Estimated Annual Savings	**$ 691,080**

* AHRQ

(Jack MD, Brian W., et al (2009). Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. *Annals of Internal Medicine*, 150(3), 178-187.)

020812601.2.2	*2.12.1*	*2.12.1A-G*	*Implement/Expand Care Transitions Programs*
ETMC Tyler			*020812601*
Related Category 3 Outcome Measure(s):	***020812601.3.5***	*3.IT-3.2*	*Congestive Heart Failure 30 day re-admission rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.12.1.P-1 Develop or implement best practices or evidence-based protocols to improve adherence to discharge and follow-up care instructions. **Metric: 2.12.1.P-1.1** Care transitions protocols. **Baseline/Goal:** Work to develop program and related protocols. **Data Source**: Documentation **Milestone 1 Estimated Incentive Payment:** $ 469,252	**Milestone 2: 2.12.1.I-11** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. **Metric: 2.12.1.I-11.1** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for care transition services. **Baseline/Goal:** Establish a baseline for patients in target population who receive transition protocol. We estimate that baseline to be 532 ETMC patients who have CHF. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $ 511,928	**Milestone 3: 2.12.1.I-11** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. **Metric: 2.12.1.I-11.1** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for care transition services. **Baseline/Goal:** 10% (53 patients) increase in number of patients who receive the protocol over a baseline of 532. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $ 513,416	**Milestone 4: 2.12.1.I-11** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. **Metric: 2.12.1.I-11.1** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for care transition services. **Baseline/Goal:** 20% (106 patients) increase in number of patients who receive the protocol over a baseline of 532. **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $ 424,127
Year 2 Estimated Total DSRIP: $ 469,252	Year 3 Estimated Total DSRIP: $ 511,928	Year 4 Estimated Total DSRIP: $ 513,416	Year 5 Estimated Total DSRIP: $ 424,127
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* **$ 1,918,723**			

Project Option: 2.4.1 – Implement processes to measure and improve patient experience.
Unique Project ID Number: 020812601.2.3 (Pass 1)
Performing Provider Name/TPI: ETMC Tyler 020812601

Project Abstract

Provider: East Texas Medical Center Tyler (ETMC) is a 454-bed, regional referral hospital dedicated to serving Northeast Texas with advanced diagnostics, medical and surgical care, obstetrical services, and a Level I trauma center. ETMC's primary service area is Smith County, but the secondary service area extends to 15 Northeast Texas counties. The total service area population is estimated at around 862,894.
Intervention: This project is to develop and implement a patient experience improvement plan in order to improve how the patient experiences care and the patient's satisfaction with the care provided.

Need for the Project: As sited in the community needs assessment (CN.4 and CN.6), high costs due to potentially preventable hospitalizations and efficiency in and effectiveness of health care delivery are needs in Northeast Texas. Improved patient satisfaction is linked to better outcomes and prevented readmissions while providing care in a more effective efficient manner.

Target Population: The target population is any person admitted to an ETMC facility as an inpatient. We expect to serve approximately 40,000 patients per year with a Medicaid and indigent share of 25%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve patient experience scores, as evidenced by reaching the 60th percentile in overall HCAHPS scores by DY 5. Patients will benefit from efficient and effective care focused on the patient's overall experience.

Category 3 Outcomes: The related category 3 outcome measure is to improve how the patient experiences the care and the patient's satisfaction with the care provided. The primary outcome measure that will demonstrate our success is to increase the average of all facilities' "overall" HCAHPS score to the 60th percentile by DY 5 as measured by an objective outsource vendor.

Project Narrative

Project Description: ETMC's goal is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, ETMC is targeting long term improvement in HCAHPS scores through the implementation of a system wide, transformative program. Accordingly, the four-year target goal is to increase overall HCAHPS scores to above the 60th %ile as measured by an objective outsource vendor.

In a broad sense, ETMC is proposing nothing short of cultural transformation aimed at improving patient satisfaction. On a more specific level however, there are 3 significant programmatic interventions that will enable such a transition:

- Infrastructure development: ETMC is proposing the development on an extensive infrastructure investment aimed at identifying, improving, tracking and maintaining organization-wide improvements.

- Administrative rounding program: ETMC plans to expand and enhance current patient satisfaction rounding efforts. While the goal is to see every patient, every day, such a rounding program will also seek to fix patient satisfaction issues such as those described in HCAHPS in real time.

- Improve the hospital discharge process: ETMC is exploring a number of ways to enhance the discharge and immediate post discharge process. For example, ETMC has employed a limited patient callback program in the past and had some measureable success in improving the satisfaction of those patients. This and similar programs will be significantly expanded to cover a wider range of patients.

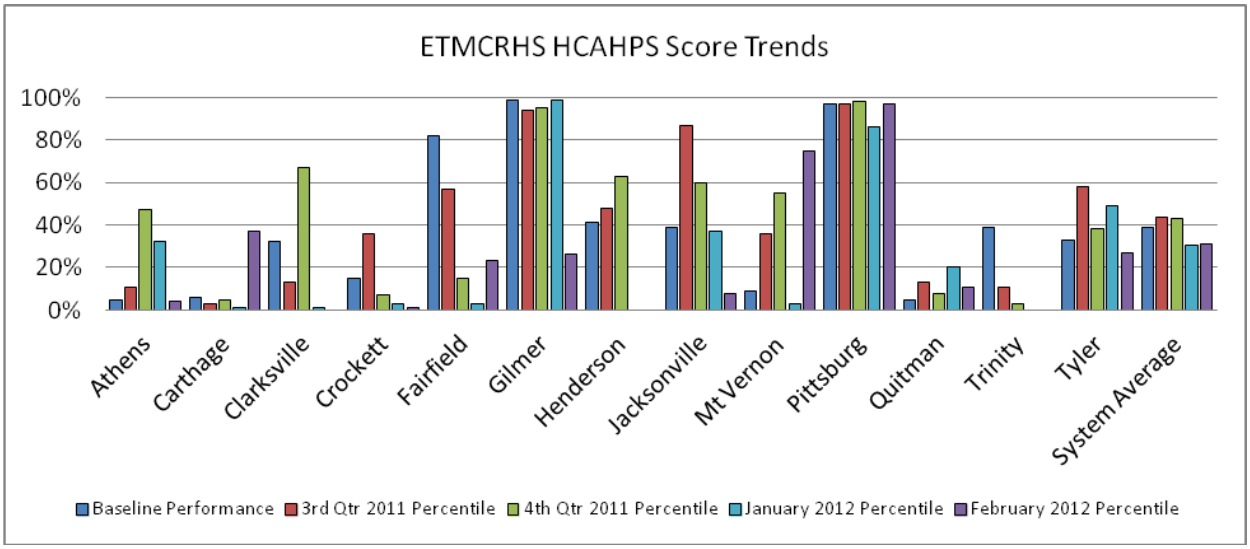
Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to improve the patient experience and decrease readmissions through improved discharge planning. Improving patient experience and decreasing readmissions meets several community needs outlined by RHP 1, including: high costs due to potentially preventable hospitalizations (CN.4) and efficiency in and effectiveness of health care delivery (CN.6).

Finally, in implementing these programs, ETMC will incorporate the following project components: **a)** Organizational integration and prioritization of patient experience **b)** Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience; **c)** Implementing processes to improve patient's experience in getting through to the clinical practice; **d)** Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Starting point/Baseline: Historically, ETMC's system hospitals have had a difficult time in achieving consistency in patient satisfaction across entities and sustaining high levels of patient

satisfaction over time. As shown in the chart below, over the past 4 reporting quarters, ETMC Tyler has had an average aggregate HCAHPS score of less than 40th %ile. ETMCRHS's goal will be to achieve 60%ile performance over time.



Rationale: Like many regional healthcare systems, ETMC is faced with the challenge of standardizing care across 14 hospitals, more than 1000 physicians in a service area that exceeds 44,000 square miles. Texas Region #1's community needs assessment (CN.6) found a significant need for improvement in efficiency and effectiveness of healthcare delivery. The System's flagship hospital, ETMC Tyler is a 400 bed Level Trauma Center is the center for much of ETMC's innovation. For example, a highly integrated system-wide approach to trauma care has been a hallmark of the System for decades. In other areas such as patient satisfaction programs, however, the ETMC hospitals have been more independent in their approach.

The real challenge for a regional system like ETMC is to identify pockets of innovation in the system that are dramatically improving quality, cost and satisfaction and transport those findings and processes around the system. A recent article suggests that one way to improve cost, quality and satisfaction is to develop more rigorous discharge processes, especially in the area of medication reconciliation and patient education. Dr. Clancy's article and other research also cite myriad programmatic interventions from around the country that aim to improve quality, cost and satisfaction.

Clancy, "Reengineering the Hospital Discharge Process: A protocol to improve patient safety, reduce cost and boost patient satisfaction." American Journal of Medical Quality, July/August 2009 vol 24, no. 344-346.

Related Category 3 Outcome Measures: The goal of implementing the patient care experience project (020812601.2.3) is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, ETMCRHS is targeting long term improvement in HCAHPS scores through the implementation of a system wide, transformative

program. The primary outcome measure that will demonstrate our success toward that goal is to increase the average of all facilities' "overall" HCAHPS score by 10% over baseline by DY 5 as measured by an objective outsource vendor (020812601.3.6).

Relationship to Other Projects: ETMC Tyler plans to implement a Patient Care Navigation Program (020812601.2.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions.

Hiring an endocrinologist (020812601.1.1) provides expansion of services for referred diabetic patients in the ED. The ED triage protocol will create the ability to refer non-urgent patients to the more efficient outpatient clinic setting. Managing the care of diabetic patients will improve health outcomes and decrease the cost of acute inpatient care. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (020812601.1.2) provides expansion of services for referred behavioral health patients in the ED. The ED triage protocol will create the ability to refer non-urgent, behavioral health patients to the more efficient outpatient and partial hospitalization services.

Expanded cardiology coverage (020812601.1.3) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing 30 day readmissions and lowering the cost of cardiac care. Moreover, expanding care transitions programs (020812601.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will also improve outcomes and decrease 30 day readmissions.

Redesigning to improve the patient experience (020812601.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: ETMC's implementation of a rigorous patient satisfaction improvement program is expected to have a measureable impact on patient safety, quality and cost. As described in the matrix below, the best aggregate measure of these items will be a system-wide improvement in percentile ranking of patient satisfaction scores at all facilities.

One specific impact of improved patient satisfaction is in the area of improving the hospital discharge process. Research in this area suggests that improved medication reconciliation, and post discharge follow-ups may have an impact on downstream re-admissions for certain target populations.

As shown in the table below, a modest 10% decrease in readmission rate for ETMC Tyler patients only (i.e. from 18% to 16.2%) could be mean a savings of as much as $3.45M to the CMS Program. Accordingly, ETMCRHS's average DSRIP funding request of $2.1M per year (Category 2 and 3) is targeted to be less than the savings of all ETMC facilities so that the CMS program accrues a net benefit.

Estimated Savings from Patient Experience Improvement	
Annual Discharges	20000
% Medicare Readmissions*	18%
Readmissions	3600
Medicare Cost per Readmission*	$ 9,600
Cost of Readmissions	**$ 34,560,000**
% Decrease in Readmissions	10%
Prevented Readmissions	360
Estimated Annual Savings	**$ 3,456,000**

* AHRQ

020812601.2.3	***2.4.1***	***2.4.1.A-D***	***IMPROVE PATIENT CARE EXPERIENCE***
ETMC Tyler			*020812601*
Related Category 3 Outcome Measure(s):	***020812601.3.6***	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores.*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.4.1.P-2 Write and disseminate a patient/family experience strategic plan. **Metric: 2.4.1.P-2.1** Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization **Baseline/Goal:** Submit the plan. **Data Source**: Documentation **Milestone 1 Estimated Incentive Payment:** $1,629,629	**Milestone 2: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Establish baseline as overall percentile ranking compared to comparably sized hospitals. ETMC Tyler's baseline HCAHPS score has been below the 40th percentile. **Data Source**: As reported by Press Ganey or similar national company **Milestone 2 Estimated Incentive Payment:** $1,777,837	**Milestone 3: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Achieve 55th %ile **Data Source**: As reported by Press Ganey or similar national company. **Milestone 3 Estimated Incentive Payment:** $1,783,005	**Milestone 4: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Achieve 60th%ile. **Data Source**: As reported by Press Ganey or similar national company. **Milestone 4 Estimated Incentive Payment:** $1,472,917
Year 2 Estimated Total DSRIP: $1,629,629	Year 3 Estimated Total DSRIP: $1,777,837	Year 4 Estimated Total DSRIP: $1,783,005	Year 5 Estimated Total DSRIP: $1,472,917
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$6,663,389***			

Project Option: 2.19.1 – Design, implement, and evaluate care management programs that integrate primary and behavioral health needs of individual patients.
Unique Project ID Number: 084434201.2.1 (Pass 1)
Performing Provider Name/TPI: Texoma Community Center 084434201

Provider: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties in North Central Texas. Fannin County is in RHP 1 and covers 890.84 square miles, with a 2011 population of 33,356 representing a 1% increase from the previous year. (1a) TCC has four clinics and staff average 10,226 face to face treatment services monthly to over 1,200 adults, children, and families ranging from birth to death, including approximately 220 in Fannin County. (1b) Less than 1% of TCC's patients have private insurance and 38% have Medicaid. Also, 81.34% of adult patients are below the federal poverty level. (1b)

Interventions: This project will implement a new initiative for TCC by incorporating a primary health care provider into the TCC behavioral health system, creating a "medical home" for the most "at risk" patients with mental illness and co-occurring chronic physical diseases. The initial intervention will allow for about 11 integrated patient encounters per month for RHP 1.

Need for the Project: TCC selected this project to enhance access to medical and behavior health services in RHP 1, identified by HRSA as an underserved behavioral health provider area. (1b) The WHO (2003) reports outcomes on blended care saying: "The burden of mental disorders is great, mental and physical problems are interwoven, primary care for mental health is affordable and cost effective, and primary care for mental health generates good outcomes." (1h) Lawrence and Kisely (November, 2010) state that: "While much attention has been focused on suicide and homicide which are associated with higher rate ratios, the public health burden associated with major chronic diseases is much higher in people with SMI. The majority of excess deaths in this population are due to physical illnesses, in particular cardiovascular disease, respiratory illness and cancer (Kisely et al., 2005; Lawrence et al., 2001; Leucht et al., 2007)." (1h-a) TCC receives no other federal funds that are being used to implement or fund this project.

Target Population: Target population for this project are mentally ill uninsured or Medicaid patients needing a primary care provider (138 current plus any new, uninsured patients residing in RHP 1).

Category 2 Expected Patient Benefits: TCC averages 160 adult mental health patients monthly in Fannin County and 62 children, totaling 222. About 62% (138) need integrated health services. This project will allow for ½ day (48 encounters) per month at an average of 17 minutes per patient, which, according to a Medscape Physician Compensation Report (2011), is the time most physicians spend with patients.(h-b) Since RHP 1 patients make up 22% of total TCC behavioral health patients, about 11 patient encounters per month will occur (132 annually). Therefore, DY 3 improvement target is for 132 encounters to occur which will then be the improvement target baseline for DY 4 and DY 5 at 25% (166) and 40% (185) increased annual encounters respectively. This project allows for a patient impact to about 27 additional people in the RHP 1 region and valuation of $248,781.00.

Category 3 Outcomes TCC's Category 3 IT-10.1 Quality of life goal is to improve functioning for TCC's most "at risk" patients with co-occurring mental and physical health problems reducing the use

of more expensive services for improved community impact. The baseline will be established in DY 2 so that impact to the regional health care system can be evaluated over the following three years.
Project Title: 2.19 – Develop Care Management Function that integrates primary and behavioral health needs of individuals.

Project Option: - 2.19.1 Project Options: Design, implement, and evaluate care management programs and that integrate primary and behavioral health needs of individual patients

Required core project components:

a) Conduct data matching to identify individuals with co-occurring disorders who are:

- not receiving routine primary care, not receiving specialty care according to professionally accepted practice guidelines,
- over-utilizing ER services based on analysis of comparative data on other populations
- over-utilizing crisis response services
- Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.

b) Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation.
c) Identification of BH case managers and disease care managers to receive assignment of these individuals.
d) Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders.
f) Train staff in protocols and guidelines.
g) Develop registries to track client outcomes.
h) Review the intervention(s) impact on quality of care and integration of care and identify"lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

Project Narrative

Description: Texoma Community Center (TCC) intends to implement a care management system that will integrate the primary physical and behavioral health care for individuals served by TCC and to broaden the services array. By providing physical health care to those patients receiving behavior health treatment, TCC will address regional needs (CN.1, CN.2, CN.4, CN.5, and CN.6) and enhance regional goals to improve the health of populations in the region, reduce the cost of health care in the region, and improve access to health care in the region. TCC intends to do this by contracting with 1 primary care physician and 1 nurse for four hours per week specifically to treat chronic physical health issues that are co-occurring with TCC's most "at risk" patients. In doing so, TCC commits to researching, establishing protocols, supporting and providing the physical health treatment alongside the psychiatric treatment in an enhanced care management model. TCC will also need to employ one full-time clerk to manage the medication acquisition through Patient Assistance Applications and other related duties. TCC receives no current federal funding for such blended care.

TCC patients have significant barriers and limited access to primary care physicians (CN.1) and case managers frequently have trouble finding physicians to prescribe physical health medications for Medicaid or low-income patients, at times putting patients at risk of not having essential

medication. Integrating physical health and behavioral health care will help solve this access problem and contribute to the regional goals to "improve quality of care and patient satisfaction, improve the health of regional populations, reduce the cost of health care and improve access to health care services—physical, mental, and behavioral health." (RHP 1 Anchor Plan)

To accomplish these goals, TCC will implement the core components including: (a) data matching to identify individuals with co-occurring disorders who, as the core components describe. are:

- not receiving routine primary care, not receiving specialty care according to professionally accepted practice guidelines,
- over-utilizing ER services based on analysis of comparative data on other populations
- over-utilizing crisis response services
- becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms.

TCC will further (b) explore and implement a chronic care management best practices protocol that is compatible with organizational readiness; (c) BH case managers will be identified in order to receive assignment of these individuals. Also, (d) protocols for coordinating care will be written and implemented and community resources and services that are available for supporting people with co-occurring disorders will be identified; and (f) staff will be trained in protocols and guidelines and a (g) registry to track client outcomes will be developed. Finally, as part of the continuing quality improvement strategies, (h) intervention impact on quality of care and integration will identify the "lessons learned," explore opportunities to scale all or part of the interventions to a broader patient population, and identify key challenges associated with expansion of the interventions, including special considerations for safety-net populations.

It is specifically noted that one of the "Core Components" for this Project Option (2.19.1) has been omitted from TCC's Project Plan at this time but will be added later. The component omitted was "e) Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression and asthma." The reason for this omission is that TCC's medical staff's area of practice is specifically psychiatry and it is believed that trying to implement physical health guidelines at this point is beyond the scope of practice. While it is the purpose and intent of this project to expand the scope of practice to treating physical health issues "in house," it is further believed that initially, it will be important for the treatment primary care physician and nurse to have time to integrate into a new environment and treatment model and to focus the limited available hours to seeing patients rather than implementing new disease management guidelines. It is believed that in hiring a well-qualified primary care physician and nurse, the ability to adequately address disease management issues will be within their expertise brought to the center. This is not to diminish the value of developing evidence-based practices and implementing those best-practices guidelines in any way, but simply to be successful over time in making a paradigm shift away for a specialty practice of psychiatry to a more blended "whole person" treatment, utilizing ALL best-practices guidelines. It is expected that as this blending of primary care and behavioral health care services is established and then expanded by increasing physician and nurse time, then it will be the time to focus on identifying and implementing more refined disease management guidelines and protocols. It is believed that by adopting and implementing all of the other Core Components, the groundwork will be established and supported for then incorporating more refined disease management protocols.

The five-year expected outcome is that current and new patients served by TCC will have quick access to both physical health treatment and psychiatric and behavioral health treatment at this center such that the most "at risk" patients will experience a quality of life improvement, improve their overall health and stabilize to reduce unnecessary emergency department visits and hospitalizations.

Baseline Data and Project Starting Point: Currently TCC does not provide any physical health treatment except for vital sign monitoring at the time of psychiatrist visits. Being able to quickly and efficiently coordinate physical and psychiatric health care and establish that medical home, would be a significant improvement in service quality, accessibility and outcomes. Currently, when physical health issues are evident, the actual treatment must be referred out to area physicians who are rapidly opting out of providing services to Medicaid patients and more often don't provide services to indigent patients. Therefore, the initial baseline for treating physical health issues that are co-occurring with psychiatric issues for TCC's high utilizer patients would be zero. The approximate 132 patient encounters in DY 3 will become the baseline for DY 4 and 5 improvement targets.

Rationale: Individuals with severe and persistent mental illness have difficulty accessing resources for all of their needs, including their basic health care needs. They encounter transportation problems, organizational problems and communication problems. They often have chronic medical conditions along with their mental illness; therefore their health and psychiatric stability is easily compromised. Individuals who are the most "at risk," where both the psychiatric issues and chronic physical issues are concerned, tend to be high utilizers of emergency rooms, psychiatric hospitals and physical, acute care hospitals. Their overall level of functioning tends to be lower than the general population. Therefore, offering and supporting physical health treatment simultaneously with their psychiatric needs would significantly reduce their risk factors and increase their overall stability, thus reducing their use of high dollar facilities. TCC has already provided evidence and data with our own ACT patients showing that increased support reduces hospitalizations and ER visits. The reduction of psychiatric hospitalization of these high utilizer patients from 1.8% being hospitalized in 2007 down to 0% in 2010 was in part due to the ACT team model including physical health awareness by: (1) having an RN on the case load who knows all ACT patients and regularly evaluates their physical health needs; (2) case manager's being made aware of physical health issues and supporting these clients in addressing physical health issues in addition to their psychiatric needs and then ensuring that they are transported to physical health appointments as needed. (32) The "wraparound" style of services for the ACT team has improved the psychiatric and physical health of these patients and supports the evidence that this ACT model of service delivery does, indeed, improve patient functioning and reduces high dollar utilization of ERs and hospitals. Having the opportunity through this Project to further broaden this style of service delivery to additional patients would enhance the cost reduction for area hospitals while improving patient outcomes.

According the World Health Organization/Organization of Family Doctors, 2000 publication entitled Integrating Mental Health and Primary Care: A Global Perspective, the lack of coordination of treatment on a world-wide scale is regretful because: "The burden of mental disorders is great, mental and physical problems are interwoven, primary care for mental health is affordable and cost effective, and primary care for mental health generates good outcomes." (34) The article points out that: "Primary care for mental health forms a necessary part of comprehensive mental health care, as well as an essential part of general primary care. However, in isolation, it is never sufficient to meet the full spectrum of mental health needs of the population." (35)

As documented in the American Journal of Psychiatry, June 1, 2008, medical costs are approaching 20% of the nation's Gross National Product, and 6.2% of those costs are directly related to mental health issues. (36) Persons with severe mental illness often have addictions, such as consuming 44% of all cigarettes smoked, that shorten their lifespan by 13 to 35 years. (37) The absence of integrated primary and medical care takes a toll on individuals, their families, their communities, and results in cost that could be greatly reduced if preventative or early medical treatment was used to avoid progression of illnesses to an acute care stage.

Approximately 40% of the people served by TCC are without a third-party payer source for medical care, leaving them to manage illnesses through expensive "band aide" treatment in emergency rooms. (38) Additionally, many of the people receiving psychiatric services are placed on powerful psychotropic medications, and are at risk for adverse effects. Although the medical staff does a good job in screening for critical conditions, such as pulmonary and circulatory problems, it is the absence of preventative or stabilizing primary medical care that prompts emergency room visits and hospital care at its highest cost end. TCC's employment of primary medical care staff to treat the most medically "at risk" individuals will create a community value that by far exceeds its cost.

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

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

The Quality of Life/Functional Status outcome domain is appropriate for this project because, again, mental/behavioral health is adversely impacted by physical health issues, and vice versa. Both reduce a patient's ability to function which adversely affects quality of life issues. Both physical and mental health problems negatively impact a person's independent living, relationships, sense of self-worth and lead to costly emergency treatment. By focusing on assessment of QOL and functional status, we will be able to determine the efficacy of combining primary care and behavioral health care treatment at one facility. The World Health Organization (WHO) issued a report called "Integrating mental health into primary care: A global perspective" and pointed out that by blending mental health treatment and primary care treatment, patients "avoid indirect costs associated with seeking specialist care in distant locations….. [and] integrating mental health services into primary care generates good health outcomes at reasonable costs."(33) Improving access to primary physical

health while simultaneously providing mental health services will, indeed, help the low-income population served in Fannin County by TCC achieve a better quality of life, reduce high dollar hospital costs and achieve positive patient outcomes.

Relationship to other Projects: This project relates to expanding telehealth services (084434201.1.1), expansion of substance abuse services (084434201.1.2) , and expanding counseling services to non-priority populations (084434201.1.3) in an integral way. Adding primary physical care to a more comprehensive behavioral health treatment program will create a complete wellness opportunity for those served. Successful development and implementation of this project will be facilitated by the other projects through streamlining information exchange and collaboration between the proposed projects. This will allow for a multi-modal approach to comprehensive healthcare for unfunded, underfunded and underserved members of our community (CN.1, CN.2, CN.3, CN.4, CN.5, and CN.6) which will assist in meeting the regional health care goals to improve quality of care, improve patient satisfaction, improve the health of populations, reduce the cost of health care and improve access to health care services. Integrating primary and behavioral health care facilitates preventive treatment and a reduction in more costly and inefficient repetition of services.

Relationship to Other Performing Providers' Projects in the RHP: The primary relationship this Project will have to the other Projects in RHP 1 is one of collaboration, sharing of data and information, and referrals as appropriate. While there are no specific TCC projects that are combined in implementation with other providers in the region, this project specifically lends itself to future collaboration as the potential to work with physical health providers blends into a holistic, patient-centered care model. Discussion has already begun with several health care providers in RHP 1, including health clinics and hospitals participating in the DSRIP service enhancement program, and a more formal collaboration is in the future. TCC will, indeed, be a part of collaboration and sharing data, knowledge and experiences with other with other stakeholders and providers in RHP 1 in order to enhance best practice models is a definite TCC goal. The need (CN.2) for additional behavioral health providers allows for service expansion, along with physical health providers, without duplicating services or even meeting the need fully.

Plan for Learning Collaborative: RHP 1 does plan to implement a Learning Collaborative within the region. Texoma Community Center plans to participate in the RHP-1 learning collaborative meetings with other providers in order to share knowledge, experience and outcomes across the region for quality improvement purposes. Part of TCC's goal is to gather information and bring new knowledge back to the management table to help direct TCC's growth and expansion toward sound, cost-effective, evidence-based practices. Focus in the learning collaborative will be to identify project impacts, what has been learned within the Center and from other entities, and expanding the projects to a broader patient population. In the case of this project, TCC will be expanding, learning and growing into an entirely new territory of combining physical health care with behavioral health care. Addressing key challenges will be done internally and as part of the learning collaborative within the region because TCC recognizes the importance of sharing project experiences and learning from others who are having similar experiences. It is important to look for solid solutions that are backed up by evidence-based research, especially in a new area for this center, so that positive outcomes can spread across the region.

Project Valuation

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

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

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. (9a)

To support the valuation methodology, several research studies were reviewed. Two studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. (9e) Drummond et al, (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. (9f) The average of these two values is 0.11135. To supplement, Dewa et al. (2009) found that collaborative care saved $503 per patient in disability benefits. (9h) Finally, Katon (2012) examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease. In this study, the effect of the intervention was 0.0335 incremental life years gained. (9g) Therefore, DY 3 improvement target is for 132 encounters to occur (for approximately 138 targeted patients) which will then become the improvement target baseline for DY 4 and DY 5 at 25% (166) and 40% (185) increased encounters respectively. This project allows for a patient impact to about 27 additional people in the RHP 1 region and valuation of $248,781.00. (9g, 9h)

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084434201.2.1	PROJECT OPTION: 2.19.1	COMPONENTS: 2.19.1.A.C.D.F.G.H	DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.5	IT-10.1	Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-5 BH case managers and disease care managers are identified & trained for blended care coordination for "at risk" patients with co-occurring mental/physical health needs. P-5.1 Metric: Number of staff identified who have the capacity to support the targeted population. **Baseline**: No BH case managers identified or trained **Goal**: Appropriate number of BH case managers are identified, hired and trained to meet the patient needs Data Source: Staff rosters and documents of caseloads/training rosters. Milestone 1 Estimated Incentive Payment	Milestone 2: P-6 -Case management and care coordination protocols are developed and operational. P-6.1 Metric - Written protocols are in place and easily available to staff. Data Source: Written protocols Baseline: No written protocols are in place Goal: Written protocols are in place, available and ready for operation Milestone 2 Estimated Incentive Payment (maximum amount): $20,660.00 Milestone 3: P-8 I physician, 1 nurse, and 1 clerical staff are hired, trained & providing services. P-8.1 Metric: Percent of staff hired/trained/working. Baseline: zero staff hired/ trained Goal: 100% staff hired/ trained	Milestone 5: I-21 - Increase use of routine preventive and primary care for identified "at risk" patients I-21.1 Metric: 25% Increase in routine visits Baseline: zero routine visits annually Goal: 25% increase (166) in routine visits Data Source: Encounter/ claims data	Milestone 6: I-21 --Increase use of routine preventive and primary care for identified "at risk" patients. I-21.1 Metric - 40% increase in routine visits Baseline: zero routine visits Goal: 40%+ increase (185) in routine visits annually Data Source: Encounter/ claims data Milestone 6 Estimated Incentive Payment (maximum amount): $64,061.00

084434201.2.1	PROJECT OPTION: 2.19.1	COMPONENTS: 2.19.1.A.C.D.F.G.H	DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS
Texoma Community Center			084434201
Related Category 3 Outcome Measure(s): OD-10	084434201.3.5	IT-10.1	Quality of Life/Functional Status

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
(maximum amount): $56,438.00	Data Source: HR records/Training records Milestone 3 Estimated Incentive Payment (maximum amount): $20,660.00 Milestone 4: I-21 - Increase use of routine preventive and primary care visits. I-21.1 Metric - Increase in number of routine preventive and primary care visits Baseline: zero visits Goal: 132 routine preventive and primary care patient encounters occur establishing the baseline for DY 4 & DY 5. Data Source: Encounter/ claims data Milestone 4 Estimated Incentive Payment: $20,660.00	Milestone 5 Estimated Incentive Payment: $66,302.00	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $56,438,00	Year 3 Estimated Milestone Bundle Amount: $61,980.00	Year 4 Estimated Milestone Bundle Amount: $66,302.00	Year 5 Estimated Milestone Bundle Amount: $64,061.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $ 248,781.00			

Project Option: 2.13.1 -- Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Unique Project ID Number: 084434201.2.2 (Pass 2)
Performing Provider Name/TPI: Texoma Community Center 084434201

Provider: Texoma Community Center (TCC) is a governmental entity known as a Local Mental Health Authority serving three rural counties in North Central Texas. Fannin County covers 890.84 square miles with a 2011 population of 33,356, representing a 1% increase from the previous year. (1a) TCC has four clinics providing 10,226 face to face treatment encounters monthly (1b) to over 1,200 adults, children, and families ranging from birth to death, including approximately 222 in Fannin County. Less than 1% of TCC's patients have private insurance and 38% have Medicaid. Also, 81.34% of adult patients are below the federal poverty level. (1b)

Interventions: This project will: "Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population." It represents both new initiatives and expanded current services for Texoma Community Center. The goals are to develop and provide a comprehensive treatment modality that includes twelve different community-based intervention options to substantially stabilize the mentally ill, functionally impaired and homeless individuals in Fannin County in order to reduce unnecessary use of emergency departments, physical and psychiatric hospitals and the criminal justice system. TCC has an excellent track record in accomplishing these type of goals already and is poised to expand these outcome successes with this extensive project.

Need for the Project: TCC selected this project because the county population is growing and there is a significant need to address a broader patient base who have more severe functional impairments. The goal is to comprehensively meet a full spectrum of needs for mentally ill patients in Fannin County, which is identified as an underserved behavioral health provider area (1c) and therefore, this project is essential to stabilize and improve additional mentally ill, homeless and/or "at-risk" individuals. No other federal resources are related to this project.

Target Population: Project 084434201.2.2 targets Medicaid-eligible and indigent individuals with mental illness, challenging functional impairments and significant community needs.

Category 2 Expected Patient Benefits: Project 084434201.2.2 will provide comprehensive community-based interventions, as outlined in the project narrative. This project has a goal to benefit 8 RHP 1 patients in DY3, 20 in DY4 and 28 in DY5 for a total of 56 and a community value of $80,248.00. It is expected the health care cost reduction for the community will far exceed this amount based on TCC's very active, daily involvement in crisis intervention, jail diversion and Mental Health Court in this county.

Category 3 Outcomes: TCC's Category 3 goal is IT-9.2 ED Appropriate to reduce Emergency Department visits for target conditions, specifically behavioral health//substance abuse
Because this is a significantly expanded service, precise numbers are not available until DY 2 of the project when a baseline will be established, therefore, outcome targets will be established and specific numbers or percentage-related metrics will be added to assess the improvements for those receiving this intervention.
Project Title: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting

Project Option: 2.13.1 -- Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Required core components:

a) Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. 201 Lewis, D., Corporation for Supportive Housing, Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010.) Retrieved from http://www.caction.org/homeless/documents/AustinModelPresentation.pdf
Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.
b) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes/quality of life.
c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
d) Design models which include an appropriate range of community-based services and residential supports.
e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

Project Narrative

Project Goal: Texoma Community Center (TCC) will provide specialized services to complex behavioral health populations, specifically severely mentally ill people in Fannin County, Texas, in order to avert potentially avoidable inpatient admissions and readmissions to a more restrictive and expensive setting such as acute care and/or psychiatric hospitals or the criminal justice system. The goal is to proactively promote wellness, medication compliance, improved functioning and recovery. TCC recognizes that the required core components will facilitate success. Therefore, the target population size, characteristics and needs will be assessed, a relative literature review will be conducted and a project evaluation plan will be developed that utilizes both qualitative and quantitative metrics. The outcome goals will be accomplished by developing and providing a comprehensive treatment modality that includes but is not limited to the following community-based interventions tailored to meet a patient's needs: (1) Integrated medical and psychiatric care; (2) Assisted living; (3) Psychosocial Rehabilitation; (4) Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens, etc; (5) Transportation to appointments and community-based activities; (6) Specialized behavioral therapies such as

Cognitive Behavioral Therapy (an empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking) or Cognitive Processing Therapy (an empirically supported treatment developed by the Veterans Administration that focuses on recovery from trauma-based injuries such as Post-Traumatic Stress Disorder and other related conditions); (7) Prescription medications; (8) Peer support service that models successful health and mental health behaviors provided by peer specialists who are in recovery from mental illness or substance use disorders and are supervised by mental health professionals; (9) Respite care (short term); (10) Substance abuse services; and (11) Employment supports.

These treatment components will be integrated into a system guided by the SAMHSA evidence-based toolkit for permanent supported housing. (1) The primary intent is to significantly enhance the current assisted living and respite care facility in order to divert the target patients who are in crisis and homeless from high cost care. As evidenced by the following chart outlining TCC internal data, TCC's original 16 bed contracted facility has been extraordinarily successful in accomplishing previous diversion goals. The intent is to broaden the scope of these services to facilitate the regional goals.

TCC will accomplish the core components by engaging in outreach and coordination with stakeholders in the community impacted by this population. TCC will further (1) assess size, characteristics and needs of target population(s); (2) review literature and experiences with target populations to determine effectiveness of community-based interventions; (3) develop project evaluation plans using qualitative and quantitative metrics; (4) Design an appropriate range of community-based services and residential supports; (5) assess the impact of interventions based using the accepted ANSA assessment tool while identifying "lessons learned," looking for opportunities to provide interventions to a broader patient populations, and identifying key challenges for safety-net populations. The impact of the interventions will be assessed relative to the target population using research-based criteria.

TCC will develop initiatives based on process improvement methodologies related to rapid communication, integrated system workflows, providing data to providers and patients, eliminating waste, enhancing provider performance and improving patient-centered care. TCC will use protocols and tools presented in the RHP Planning Protocol Manual (p. 301) designed to identify project impacts, and understand what "lessons have been learned" in order to "solve key challenges that address the special considerations for these target populations. (2)

TCC will accomplish the core components by coordinating with stakeholders in the community impacted by this population. TCC will provide the required training and education to staff on the component elements to facilitate patient recovery. TCC will continue to address issues of safety, quality, and efficiency through continuous quality improvement. This will contribute to the overarching regional (RHP 1) goals of improving quality of care and patient satisfaction, improving the health of the regional population, reducing the cost of health care, and enhancing access to health services while improving preventive care. (RHP 1 Anchor Plan)

The expected five-year outcome is to have a thriving, adaptive, well-organized, evidenced-based, comprehensive program that provides both transitional services from homelessness or crisis to independent living, as well as supported assistive living for those in the community with more profound disabilities, for at least 56 individuals. This program will allow for the greatest measure of independence and self-direction possible and it is expected that in five years the program will reduce health care costs, incarcerations and produce significant positive outcomes for the target population. (CN.1, CN.2, CN.4, CN.5, CN.6)

Starting Point/Baseline: While TCC continuously provides appropriate interventions for patients with severe and persistent mental illness and has diligently worked to stabilize behavioral health patients in order to reduce hospitalizations and emergency department visits and increase recovery, expanding and refining these efforts will have a much greater positive impact on community health resources. While Quality Improvement has always been a priority, TCC has not had an organized set of evidenced-based strategies, tools or reporting

capabilities in place. Utilizing quality improvement process tools along with expanded intervention strategies will lay the foundation for a project baseline that will be established in DY 2.

Rationale: TCC does not have any other federal funding sources related to this project and selected this project in order to impact the homeless mentally ill (target population) in Fannin County, Texas and expand positive interventions across the region to further reduce unnecessary use of expensive health services. TCC is starting this project with an established "track record" in stabilizing high-utilizer patients in the area's medical community. The following "look back" at what TCC has accomplished during the past six years is only to exemplify what can be accomplished if these efforts are refined and expanded to a regional level. Since 2006, TCC's management team has made comprehensive changes through an on-going process of consistent communication with patients and staff, solicitation of stakeholder feedback and through use of solutions-focused, problem-solving responses. The changes and collaborations had a significant impact on improving the Center's financial stability and contributed to positive outcomes for patients. The first major change occurred with the Assertive Community Treatment Program (ACT) for those with the most severe and persistent mental illness. The result was a reduction of average psychiatric hospitalizations for this discreet population over a four-year time period from 1.8% in 2007, 1.6% in 2008, .23% in 2009, 0% in 2010. (3) Also, other "high utilizer" patients are in TCC's out-patient psychosocial rehabilitation program. This group showed a reduction in crisis events (and thus trips to the emergency room) from an average of 4.6% in 2010, to 3.4% in 2011 and just 1.1% in the first half of 2012, indicating that service delivery improvement does, indeed, improve patient functioning and, in turn, reduces high dollar emergency department utilization. (4) The following internal data exemplify goals that are completely consistent with current regional transformation goals. TCC intends to continue this improvement model by expanding the intervention base, improving the range of community-based services and by engaging in performance improvement to reduce inefficiencies, waste, and barriers:

	FY06	FY 07	FY 08	FY 09	FY 10	FY 11	%
MEDICATION COSTS	$905,652	$191,491	$152,257	$132,072	$93,355	$72,511	-92%
HOSPITAL COSTS	$346,530	$126,575	$64,929	$40,197	$18,375	$12,600	-97%
OUTREACH EFFORTS	Began jail diversion began; med formulary	Began mobile crisis team & Crisis Residential unit; trained Judges& ER; ↑PAP	Mental Health Court in 1 county	Begin Drug Court involvement & enhanced community training	Began telemed services in all county offices & in 1 jail	Continued outreach efforts and increased trainings in community	

(5)

Medication costs were reduced by addressing prescribing practices and adhering to a medication formulary and by aggressively pursuing Patient Assistance Program medications. This improvement trend has continued into 2012. Increased intervention by the Mobile Crisis Outreach Team (MCOT) in the five area emergency departments (EDs) has resulted in more appropriate dispositions of crisis events and fewer overall hospitalizations. There was a critical need in the community for an alternative to hospitalization for individuals in crisis but who did not REQUIRE hospitalization. It was determined that a 16-bed crisis residential unit (CRU) would be the most cost-effective option for TCC and this was implemented in 2007. When the TCC Crisis Team is called for an assessment, local psychiatric hospitalizations were dramatically reduced. It is important to note, that an identified barrier to hospital cost reduction was the need to educate local ED doctors to allow TCC crisis staff to make the outcome determination during a crisis. Internal data showed that when ED doctors dictated the outcome as was done prior to 2007, hospitalizations were excessive, but when TCC crisis staff made the determination for the least restrictive environment (LRE), patients were effectively

stabilized in less costly environments, with continued follow up, and no increase in negative patient outcomes**.** This collaborative initiative resulted in state-funded local hospital costs being reduced to zero for the past 18 months. (6) The TCC internal data is consistent with research conducted by Scott (2000) who stated: "…..patients using MCOT versus normal care were 27 percentage points less likely to be hospitalized and had $443 lower expenses." (9c) In 2010, Red River Regional Hospital in Bonham (Fannin County) reported 7,616 emergency room visits. Reducing these visits, or subsequent psychiatric hospitalizations, by even 5 or 10 % would be a significant health care resource savings for Region 1. (7)

As demonstrated above, enhancing the intervention strategies to the target population, as well as refining quality improvement and data management strategies, will significantly enhance health transformation goals to reduce high dollar hospitalizations and incarcerations. This enhancement is essential to continue TCC intervention endeavors, support the regional goals, and address the identified regional needs (CN.1, CN.2, CN.4, CN.5, CN.6).

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

a. Reduce Emergency Department visits for target conditions
    - Behavioral Health//substance Abuse

The Right Care, Right Setting Outcome Domain was selected by TCC in order assess service delivery impact specific to target population who are individuals with mental illness, emotional disturbance and substance abuse issues who live within the region. This Project will assess the impact that interventions have in relation to reducing emergency department visits. It is recognized that positive improvement requires relentless focus on patient outcomes.

While the Right Care, Right Setting Domain seems to be a simple and single evaluation focus, directing attention and tracking the data for related hospitalizations and incarcerations will provide a more complete picture of the intervention impact on the behavioral health status of Fannin County's low-income, mentally ill population. Tracking the reduction in hospitalizations is particularly important in reducing overall health-related costs. In fact, Fannin County's health ranking from the US Department of Health & Human Services' *"2012 County Health Rankings"* shows that Fannin County residents have "5.3 poor mental health days" compared to the Texas average of "3.3 poor health days" and even more significant is that Fannin residents have "7.3 poor physical health days" (CN.1) compared to the Texas average of "3.6 poor health days;" furthermore, Fannin County shows to have identified "83 preventable hospital stays, compared to the Texas average of 73 hospital stays." (8) Individuals who are in poor mental or physical health are the very individuals who seek emergency treatment if they lack health insurance and use the ED as a primary care clinic for minor medical issues. With dedicated intervention strategies such as those described in this project, TCC will be able to focus on tracking, assessing and reducing ED use, hospitalizations, incarcerations and urgent care use, accomplishing desired Category 3 goals (CN.1, CN.3, CN.4, CN.5).

Relationship to other Projects: This intervention project will contribute data relative to other projects submitted by TCC for health care transformation. Community–based interventions designed to stabilize additional low-income, mentally ill individuals in this region will impact the success of ALL other Pass 1 TCC projects (084434201.1.1, 084434201.1.2, 084434201.1.3, 084434201.2.1) as well as further regional health care goals, such as reduced health care cost.

Relationship to Other Performing Providers' Projects in the RHP: Several performing providers in this region are expanding their intervention strategies**;** therefore, collaborating on experiences and processes will improve outcomes. There are no specific TCC projects that are combined in implementation with other providers in the region, but collaboration and sharing data, knowledge and experiences with other providers

in RHP 1 is a definite TCC goal. Lakes Regional MHMR Center, Andrews Center, ACCESS Services, Community Healthcore, and Burke Center all plan to expand behavioral health care within this region, so it is anticipated that strategy-sharing, data sharing and collaboration will enhance the goals. The need for additional behavioral health providers and additional services (CN.2) allows for all RHP 1 LMHA's to expand behavioral health services without duplicating services or even fully meeting the need.

Plan for Learning Collaborative: The RHP 1 Anchor plans to implement Learning Collaborative opportunities for regional providers, and TCC will participate with other providers in the region in order to exchange project experiences to facilitate regional success. TCC will participate in the Learning Collaborative and will bring information back to the management table to direct future growth toward cost-effective, evidence-based practices to reduce health care costs.

Project Valuation: Providing community-based interventions for the targeted health population of homeless mentally ill patients is consistent with the U.S. Department of Health and Human Services' objective to: "Reduce the growth of healthcare costs while promoting high-value effective care." **(9)** TCC agrees with the HHSC Strategic Plan that: "From the perspective of a service provider or program manager, quality ensures effectiveness and efficiency. From the perspective of the policy maker, quality is the key to improving the mental health population, ensuring value for money expended and accountability." **(10)**

Valuations should be based on economic principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. A cost-utility analysis by Holtgrave, (2012) was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is $62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life**. (9a, 9b)** A study by Jones, et. al. (2003) show that participants receiving the critical care intervention had 58 fewer homeless nights, compared with standard treatment participants. A night of homelessness was valued at $152.00 using a societal perspective which results in a value gain of $8,816 per participant. (9j) For supportive housing, Larimer, et. al. (2009) showed that this type of program for chronically homeless individuals with severe alcohol problems showed a cost offset of $2,449 per month per individual. (9k) Utilizing this methodology, this project's value will be $91,058.00 and benefit a minimum of 56 low-income individuals in this region who will receive combination of recommended community-based interventions depending on individual need during DY3, DY4 and DY5.

Milestones/Metric Table for Project:

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.6	IT-9.2	ED appropriate utilization (Standalone measure)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-2 Design community-based specialized interventions for target populations, including significantly expanded respite & residential facility. P-2.1. Metric- Project plans which are based on evidence/experience and need which address the project goals Baseline: No Project plan in place Goal: Evidenced-based project plan in place addressing goals. Data Source: Project Documentation, Expansion Plans Milestone 1 Estimated Incentive Payment (maximum amount): $17,680.00	Milestone 2: P-3 Secure residential facility & enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) P-3.1 Metric –Increase number of targeted individuals served Baseline: Zero served with comprehensive services Goal: 8 Served Data Source: Related financial documents/lease agreements/ contracts in place/service encounter data and residential facility enrollment data. Milestone 2 Estimated Incentive Payment (maximum amount):	Milestone 4: P-3 Secure residential facility & enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, substance abuse, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) P-3.1 Metric – Increased number of targeted individuals served Baseline: Zero served with comprehensive services Goal: 20 served Data Source: Related financial documents/lease agreements/ contracts	Milestone 6: P-3 Secure residential facility & enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, substance abuse, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities) P-3.1 Metric – Increased number of targeted individuals served Baseline: Zero served with comprehensive services Goal: 28 served Data Source: Related financial documents/lease agreements/ contracts

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.6	IT-9.2	ED appropriate utilization (Standalone measure)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	$9,930.00 Milestone 3: P-4-Evaluate and continuously improve interventions P-4.1 Metric – Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles (e.g., how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Baseline: Quality Improvement Cycle not in place and evident. Goal: Quality Improvement Cycle in place and evident through weekly reports/ dashboards. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality Milestone 3 Estimated Incentive Payment (maximum amount):	in place/service encounter data and residential facility enrollment data. Milestone 4 Estimated Incentive Payment $10,822.00 Milestone 5: I-5 Functional Status I-5.1 Metric - Increased number of individuals receiving specialized interventions who demonstrate improved functional status on the ANSA or CANS assessment from the pre-intervention baseline on subsequent assessment. Baseline: Initial ANSA/CANS administered prior to interventions Numerator: Percent of individuals receiving specialized interventions demonstrating improvement from baseline on functional	in place/service encounter data and residential facility enrollment data. Milestone 6 Estimated Incentive Payment $10,531.00 Milestone 7: I-5 – Functional Status P-5.1Metric - Increased number of individuals receiving specialized interventions who demonstrate improved functional status on the ANSA or CANS assessment from the pre-intervention baseline on subsequent assessment. Baseline: Initial ANSA/CANS administered prior to interventions Numerator: Percent of individuals receiving specialized interventions demonstrating improvement from baseline on functional assessment.

084434201.2.2	PROJECT OPTION: 2.13.1	COMPONENTS: 2.13.1. A-E	PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.).	
Texoma Community Center				084434201
Related Category 3 Outcome Measure(s): OD-9	084434201.3.6	IT-9.2	ED appropriate utilization (Standalone measure)	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	$9,930.00	assessment. Denominator: The number of individuals receiving specialized interventions Goal: 20% of enrolled patients show improved ANSA/CANS assessment scores Data Source: Pre-and-post- treatment ANSA scores for target population Milestone 5 Estimated Incentive Payment (maximum amount): $10,823.00	Denominator: The number of individuals receiving specialized interventions Goal: 30% of enrolled patients show improved ANSA/CANS assessment scores Data Source: Pre-and-post- treatment ANSA scores for target population Milestone 7 Estimated Incentive Payment (maximum amount): $10,532.00
Year 2 Estimated Milestone Bundle Amount: $17,680.00	Year 3 Estimated Milestone Bundle Amount: $19,860.00	Year 4 Estimated Milestone Bundle Amount: $21,645.00	Year 5 Estimated Milestone Bundle Amount: $21,063.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $80,248.00			

Project Option 2.9.1 – Provide Navigation Services to Targeted Patients Who Are at High Risk of Disconnect from Institutionalized Health Care.
Unique Project ID: 094095902.2.1 (PASS 1)
Performing Provider Name/TPI: Good Shepherd Medical Center – Longview 094095902

Project Abstract

Provider Description: Good Shepherd Medical Center (GSMC) is a 425-bed not-for-profit hospital serving counties in rural East Texas, known as the Piney Woods. The hospital is a safety net, Level II Trauma Center with a catchment area of 11 counties, approximately 6,298.92 square miles. The total population of the 11 counties being served by the hospital is 433,000. GSMC operates two (2) Emergency Departments located in Gregg County. This project is expected to reduce admissions and repeat admissions into the hospital through the ED for psychiatric patients and thus increase the availability of the hospitals to treat non-psychiatric patients. In addition, the hospital provides specialized care in neonatology, cardiology, neurology, pulmonology, urology, gastroenterology, and rehabilitation.

Intervention: This project will use community health workers, case managers, or other types of health care professionals as patient navigators to engage and divert non-urgent care patients from the Emergency Department to site-appropriate locations.

Need for the Project: The Emergency Department is increasingly being used by patients with non-emergency conditions. The need for this project is to help these patients navigate through the continuum of health care services, including finding a medical home that will improve health outcomes and reduce costs associated with cyclical crises and inappropriate reliance on Emergency Departments (EDs).

Target Population: The populations the Care Navigator Project will target are those who seek care in the ED without emergent conditions. Their characteristics are: patients with no PCP or medical home, frequent ED utilization, homelessness, low-income and/or no insurance, low health literacy and Limited English Proficiency. The project will develop policies and procedures to help identify, triage and manage the target population to include referral, navigation protocols/algorithms, service maps or flowcharts. It is anticipated that patients will be screened for Medicaid/Medicare eligibility and a significant portion will be eligible for Medicaid/Medicare. During demonstration year three (DY3) 500 individuals will be served through the Navigator Program.

Category 1 or 2 Expended Patient Benefits: The expected benefits of the project are: a 10% increase over baseline number of PCP referral for patients without a medical home who use the ED, urgent care, and/or hospital services; 10% reduction in ED visits pre- and post-navigation services by individuals identified as ED frequent users.

Category 3 Outcomes: IT-9.2 GSMC will identify frequent ED users and use navigators as part of a preventable ED reduction program collaborating with Community Healthcore lead agency for the East Texas Aging Disability Resource Center and through the network will liaison with other community resources to address non-medical needs.

Project Narrative

Brief Description/Delivery System Solution Proposed: Care navigation is a unique service where a "trusted advisor", a navigator, guides individuals and families through the sometimes complex health system. Assisting individuals in "navigating" through the appropriate steps when seen in health settings that are often scary and difficult to manage and often complicated by severe mental illness, the care navigator will assist in linking to specific professionals/systems and explaining options to individuals and families to provide "the right care at the right time in the right setting." No other federal funding sources or programs supported by federal funds have been identified relating to this project.

GSMC will identify frequent ED users and use navigators as part of a preventable ED reduction program collaborating with Community Healthcore lead agency for the East Texas Aging Disability Resource Center and through the network will liaison with other community resources to address non-medical needs.

The Patient Care Navigation Program will recruit, train, and monitor skilled Patient Care Navigators (PCN) serving persons with severe mental illness and chronic medical conditions to assist in preventable ED admissions. Training will include relationship building, problem solver, resource locator, and system navigation. Certified PCNs will make contact with clients and review both behavioral and physical health needs. PCNs will work with each individual in helping coordinate upcoming appointments and to identify emerging needs. The PCN will assist the client in accessing physical health services and help them understand treatment options if needed and increase access to care management and/or chronic care management, including education in chronic disease self-management.

Required Core Project Components:

a. Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b. Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c. Connect patients to primary and preventive care.
d. Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Goal(s):

Project Goal: The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to engage with patients in a culturally and linguistically appropriate manner and provide enhanced social support and culturally competent care to vulnerable and high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of health care services, ensure coordinated, timely, and site-appropriate health care services and assist in diverting non-urgent care from the Emergency Department to site-appropriate locations. Patient navigators will fill resource gaps in crisis stabilization, care transitioning and accessible primary care that will improve health outcomes and reducing costs associated with cyclical crises and inappropriate reliance on Emergency Departments (EDs).

Starting Point/Baseline:

~~As a determinate of baseline activity Good Shepherd Medical Center extrapolated from emergency department activity and based on the analytical review of the data GSMC estimates than in Waiver Demonstration year three (DY3) 500 individuals will be served through the Navigator Program.~~
Based on internal analysis of emergency department activity GSMC estimates an annual baseline of 500 individuals that would benefit from a Navigator Program. These individuals are identified by repetitive emergency department encounters or with chronic conditions indicative of repeat emergency department episodes and no medical home that might otherwise prevent emergent episodes. GSMC has set an annual benchmark of 500 unduplicated admissions into this program beginning in Waiver Demonstration year three (DY3). GSMC will assess an annual recidivism rate within this baseline count for DY3 to establish a baseline of repeat emergency room encounters within a 30, 90, and 180 days from initial encounter. Metrics in subsequent years will build on this baseline unduplicated count with an incremental increase of unduplicated admissions into the program of 10% for DY4 and 15% for DY 5. Reductions in repeat admissions will decrease by 10% from DY 3 to DY4. Reduction in recidivism from DY4 to DY5 will be 15%.

Rationale:
A regional planning group of stakeholders met to explore ways to solve a long-standing problem of overuse of limited Emergency Room resources by adults with serious mental illness. The development of **Project Option 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED)**, will meet this unique need for this area. All required core project components are applicable and will be met. This will meet the specific community need CN.5 of the RHP1 Community Needs Assessment through this new initiative of GSMC, the Performing Provider. The approach, which is affordable and easy to implement, includes establishment of a Patient Navigator Program designed to identify frequent ED users, particularly psychiatric patients that enter for non-medical reasons and preserve scarce ER resources for medical patients. Adults served through the Patient Navigator Program will be connected to continuing, integrated behavioral and physical health care to prevent or diminish future crises and provide care transitioning services.

Challenges/Community Need and How the Project is Related to the Regional Goals:
Individuals and families are faced with trying to work through complex health and social service systems. Many with lack of impartial advocates and who have never successfully moved through these systems are left on their own to attempt to understand the complexity of the managed care system with multiple plans and benefit programs. Rural locations lack transportation and further exacerbate high percentages of no shows / failure to keep appointments resulting in missing medication follow-up and rapid re-entry into the ED. Collaboration with the local mental health authority, Community Healthcore and local hospitals monitored this cycle over the past year and found that the average length of wait in the ER for a psychiatric patient was 9.2 hours. Their presenting problems tended to be psychiatric, with only 5% admitted for medical care. Similarly, adults with serious mental illness (SMI) across the county have been found to have a far higher incidence of chronic disease, exacerbated by failure to seek timely care.

Expected Outcome:
Evidenced based patient care navigation program to coordinate behavioral health and physical needs of individuals living in rural East Texas. Staff deployment in the community and in Emergency Departments (ED), the establishment of a regional patient registry will provide navigator guidance to individuals and families, monitor compliance and outcomes and verify they are not disconnected from health care institutions.
The project will meet CMS three part aim as follows:

Improved care

Result in individuals being served in the appropriate location with the appropriate treatment, and to increase GSMC's ability to provide "the right care at the right time in the right setting."

Improved health outcomes

All partners providing behavioral or physical health care will have access to the regional intake and patient registry system to enhance continuity, support medication reconciliation and avoid duplication of effort.

Lower costs

The number of psychiatric patients seeking treatment from an ED will be reduced, lowering costs and increasing their likelihood of receiving the appropriate services in the appropriate setting.

Related Category 3 Outcome Measure(s):

IT-9.2 ED appropriate utilization *(Standalone measure)*

- Reduce Emergency Department visits for target conditions
    - Behavioral Health/Substance Abuse

- Data supporting why these outcomes are a priority for the RHP;
    - There is an over-whelming need for crisis care among adults with SMI, the absence of which is hindering the delivery of emergency services at all regional hospitals. For example, in 2011, the emergency rooms at CHRISTUS St. Michael and Good Shepherd-Longview Hospitals saw 3,292 cases that primarily involved a mental health crisis and 689 had to be transported to the state hospital. A Crisis Center could have better met their needs and more durably relieved their symptoms. There are rural communities across America dealing with the same or similar dynamics. Researchers have found that 20% of nonmetropolitan counties are without mental health services and 87% of federally designated Mental Health Professional Shortage Areas in the nation are in nonmetropolitan counties[52]. Inserting small crisis stabilization points in a rural, under-resourced region is an achievable and affordable step toward building a comprehensive mental health framework.
- Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
    - There is growing recognition across health care systems that patient-centered, coordinated care is both efficient and effective. In the "Crossing the Quality Chasm" report, the Institute of Medicine (IOM) verified this assertion[53]. Similarly, a rural hospital in east Texas, CHRISTUS St. Michael, monitored this cycle over the past year and found that the average length of wait in the ER for a psychiatric patient was 9.2 hours. Their presenting problems tended to be psychiatric, with only 5% admitted for medical care. However, severely limited regional resources for inpatient psychiatric care (the closest state hospital is 100-200 miles away) mean ERs often have to hold these patients for days before a bed becomes available. The backlog created by the inappropriate use of ERs has negative ramifications for the larger community, especially medically compromised patients who have difficulty accessing care because the ERs are inundated with adults with SMI.
- Explanation of how focusing on the outcomes will help improve the health of low-income populations.

[52] Texas A&M University, Southwest Rural Health Research Center.

[53] Institute of Medicine, Committee on Quality of Health Care in America. CROSSING THE QUALITY CHASM: A New Health System for the 21st Century**.** 2001

- In this region, the responsibility for continuity care often shifts to ill-equipped primary care providers. As part of the FQHC system, ETBH and TCC are optimally prepared and funded to fulfill these functions and coordinate care among all providers.

Relationship to other Projects:
This project will assist in **2.15.1 - Integrated Behavioral Health and Primary Care** by appropriate referrals from ED's and the Crisis Center keeping primary care settings able to appropriately **1.1.2 Expand Primary Care Capacity** without the extended time in dealing with individuals that need a stable location apart from the ED or primary care physician office. The RCRC will assist in **1.9.2 Improve Access to Specialty Care** through a specific location for emergency crisis response and thereby relieve local psychiatrists' offices from community crisis response. The RCRC will also **2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting.** It will support **2.13.1 - Jail Diversion Expansion** by providing early intervention and appropriate referrals to the criminal justice system. It could further support **1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization.** This would no doubt aid in **2.4 Redesign to Improve Patient Experience.**

Relationship to Other Performing Providers' Projects in the RHP:

Community Healthcore is proposing a crisis stabilization project that will be addressing similar issues.

Plan for Learning Collaborative:
The Patient Navigator Program would participate in learning collaborative if similar projects are available. A "lessons learned" action will be put in place. A plan for Rapid Cycle Change and development of a Team to collect data, develop a "college of lessons learned" for use in continuous quality improvement will be implemented. Date TBD.

Project Valuation:
Valuing was determined using the following information related to cost savings related to use of navigators. Calculating cost reductions is complicated, but local studies have demonstrated significant savings. Among diabetes patients in Baltimore, intervention by a community health worker resulted in savings of $2,245 per patient, while costs for asthma patients in Hawaii were cut from $735 to $181 through reduced emergency room visits and improved quality of life. In Denver, case management by community health workers saved $2.28 for every $1 spent on the program.

~~[Unique Category 1 Project Identifier, e.g. Project [TPI].1.1]~~ 094095902.2.1	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 2.9.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ ~~2.9.1.A.B.C.D.E~~	Emergency Department Navigator Program
Good Shepherd Medical Center			094095902
Related Category 3 Outcome Measure(s): 094095902.3.1	~~[unique Category 3 IT identifier(s)]~~ 3.IT-9.2	~~[Reference number(s) from RHP PP]~~ ~~P-1,P-2,P-4,~~	~~[Outcome Measure (Improvement Target) Title(s)]~~ ED appropriate utilization (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestones **Milestone 1:** **P-1.** Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. **Metric 1:** **P-1.** Provide report identifying the following: • Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). • Gaps in services and service needs. • How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). • Ideal number of patients targeted for enrollment in the patient navigation program. • Number of Patient Navigators needed to be hired.	**Process Milestones** **Milestone 2:** **P-2.** Establish/expand a health care **navigation program to provide support to 500 individuals from patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. This unduplicated count will serve as the project baseline.** **Metric 2:** **P-2.1.** ~~Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.~~ Three persons will be recruited and trained to serve as patient navigators. a. Workforce development plan for patient navigator recruitment, training and education	**Improvement Milestones** **Milestone 3:** ***I-6.*** *Milestone: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.* **Metric 3:** **I-6.1.** 10% Increase number of PCP referral for patients without a medical home who use the ED, urgent care, and/or hospital services. *ata Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.* **I-6.2**. 10% Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED c. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.	**Improvement Milestones** **Milestone 4:** *I-7. Milestone: Reduce number of ED visits and/or avoidable hospitalization for patients enrolled in the navigator program.* **Metric 4:** 0% Reduction of ED visits and/or avoidable hospitalizations. *ta Source: EHR, navigation program database, ED records, inpatient records* Milestone 4 Estimated Incentive Payment *(maximum amount):* $193,375 **Milestone 5:** *lestone: Reduction in ED use by identified ED frequent users receiving navigation services.* **Metric 5:** 0% Reduction in ED visits pre- and post-navigation services by individuals identified as ED frequent users.

~~[Unique Category 1 Project Identifier, e.g. Project [TPI].1.1]~~ 094095902.2.1	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 2.9.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ ~~2.9.1.A.B.C.D.E~~	Emergency Department Navigator Program	
Good Shepherd Medical Center				**094095902**
Related Category 3 Outcome Measure(s): **094095902.3.1**	*~~[unique Category 3 IT identifier(s)]~~* **3.IT-9.2**	*~~[Reference number(s) from RHP PP]~~* ~~P-1,P-2,P-4,~~	*~~[Outcome Measure (Improvement Target) Title(s)]~~* **ED appropriate utilization (Standalone measure)**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
• Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients *Data Source: Program documentation, EHR, claims, needs assessment survey* *Rationale/Evidence: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions.* Milestone 1 Estimated Incentive Payment *(maximum amount):* $515,950	**P-2.2. Rationale: A navigator's education and skill level are main determinants of the cost of patient navigation. Education, a typical gauge for salary, can range from a peer educator recruited from the community and trained in a clinical setting to an oncology research nurse with a graduate degree. Metric: Number of unique patients enrolled in the patient navigation program;** **c. Data Source: Patient navigation program materials and database, EHR** **P-2.3. Frequency of contact with care navigators for high risk patients.** **c. Data Source: Patient navigation program materials and database, EHR**	Milestone 3 Estimated Incentive Payment *(maximum amount):* $520,625	*ta Source: Claims and EHR/registry* Milestone 5 Estimated Incentive Payment *(maximum amount):* $193,375

~~*[Unique Category 1 Project Identifier, e.g. Project [TPI],1.1]*~~ *094095902.2.1*	~~*[Reference number of Project Option from RHP PP – e.g. 1.X.X]*~~ ***2.9.1***	~~*[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]*~~ ~~2.9.1.A.B.C.D.E~~	**Emergency Department Navigator Program**	
Good Shepherd Medical Center				**094095902**
Related Category 3 Outcome Measure(s): **094095902.3.1**	*~~[unique Category 3 IT identifier(s)]~~* **3.IT-9.2**	*~~[Reference number(s) from RHP PP]~~* ~~P-1,P-2,P-4,~~	*~~[Outcome Measure (Improvement Target) Title(s)]~~* **ED appropriate utilization (Standalone measure)**	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	estone 2 Estimated Incentive Payment *(maximum amount):* $557,813		
Year 2 Estimated Milestone Bundle Amount:**$**515,950	Year 3 Estimated Milestone Bundle Amount: $557,813	Year 4 Estimated Milestone Bundle Amount: $520,625	Year 5 Estimated Milestone Bundle Amount: $386,750
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,981,138			

Project Option: 2.5.1 Redesign for Cost Containment
Project Identifier: 094108002.2.1 (Pass 1)
Performing Provider Name/TPI: Mother Frances Hospital/094108002

Project Abstract

Provider Description: Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. Mother Frances Hospital-Tyler had almost 100,000 inpatient and outpatient encounters from Medicaid and self pay on an annual basis. This represents about 20% of the hospital's total volume and the costs to treat these patients were over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances.

Intervention(s): The goal of this project will be to focus on obtaining measures that provide insights into improved opportunities for health care cost effectiveness. The project will implement processes and systems needed to identify, analyze, and lower the cost of care to patients, employers, and the government while maintaining high quality outcomes.

Need for the Project: The rate of healthcare spending is in the United States is unsustainable. To be more flexible and able to react to change in the delivery system, a clear and concise understanding of the cost systems is essential. As the demand for services increases and the growth under the waiver is implemented, a cost accounting system must be in place to ensure sustainability of the programs. Tied with the implementation of an electronic health record with the ability to track the use of standardized protocols across the system, costs will be driven down and the need to validate the savings through a new cost accounting system will be critical.

Target Population: Implementing a cost accounting system that lays the foundation for the use of data-based cost and quality measures will determine cost efficiencies and allow TMF the opportunity to provide value based health outcomes for our entire population. Medicaid and self pay populations comprise 20% of the patients served.

Category 2 Expected Patient Benefits:
This project will result in improved care delivery and reduced healthcare costs for all patients served by Trinity Mother Frances Hospitals and Clinics. Currently TMF serves approximately 500,000 patients of which 20% are Medicaid and self pay.

Category 3 Outcomes: IT-5.1 Improved cost savings: Demonstrate the cost savings in care delivery. The expected results of the redesign of the cost containment initiative are to make the provision of health care more efficient and effective by implementing a cost accounting system.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Mother Frances Hospital – Jacksonville and Mother Frances Hospital – Winnsboro. By working as a health care system the impact on recruitment and access to providers is larger and possible for not only the primary service area but also our rural region thus expanding the impact to the RHP#1.

Additionally, the impact of the cost savings projects will make a significant impact on all three hospitals. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformational project be available to the rural hospitals. The lessons learned will be shared across the region.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

Project Narrative

Project Description: The goal of this project will be to focus on obtaining measures that provide insights into improved opportunities for health care cost effectiveness for Trinity Mother Frances Hospitals & Clinics. The project will implement processes and systems that are needed to identify, analyze, and lower the cost of care to patients, employers, and the government while maintaining and improving high quality outcomes. In the era of reform and reduced reimbursements, hospitals and health systems face an imperative to deliver high quality services with broad access for patients at a lower cost.

Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. Mother Frances Hospital-Tyler had almost 100,000 inpatient and outpatient encounters from Medicaid and self pay on an annual basis. This represents about 20% of the hospital's total volume and the costs to treat these patients were over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances.

Why redesign for cost containment? Moody's Investor Services noted in their May 9, 2012 Special Comment publication that healthcare inflation has outpaced United States inflation for more than a decade. The rate of healthcare spending in the United States is unsustainable.

To be more flexible and able to react to changes in the delivery system, a clear and concise understanding of the cost systems is essential. This project will provide the tools to analyze current costs structures and design and implement efficiencies that will ultimately result in reduced costs within the system and to patients.

Goals and Relationship to Regional Goals: This project will complement the regional goal identified in the Community Needs Assessment: CN.6 "Efficiency in and effectiveness of health care delivery." By increasing the financial efficiency of its systems Trinity Mother Frances Hospitals & Clinics will have the financial stability to continue to address other community needs and serve additional patients. Other health systems will be interested in the outcome of this project and may want to replicate them.

Project Goals:

- Obtain measures that provide insights into improved opportunities for health care cost effectiveness
- Implement processes and systems needed to identify, analyze, and lower the cost of care to patients, employers, and the government
- Maintain high quality outcomes

This project meets the following regional needs:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Challenges: Trinity Mother Frances Hospitals & Clinics' internal operating systems need modifications to realign and improve the opportunities for cost efficiencies and to move towards an outcome-based payment. Trinity Mother Frances Hospitals & Clinics has not been able to provide necessary data to teams to allow transformation of care. While half of the patients enter the system through the physician integrated network, the other half come from providers who have to date shown no interest in working on cost containment. Until there is reliable and systematic data, these providers are not engaging in the process of lowering the costs.

Delivery System Solution: Trinity Mother Frances Hospitals & Clinics leadership will embark on the development of an integrated care model with outcome based payments for its delivery system. Collaborative processes will leverage the unique integration of Trinity Mother Frances hospitals' and over 350 employed physicians and mid level practitioners.

For the purposes of this project, a cost accounting system will be selected, tested, and implemented and appropriate targeted analysis will be conducted. The project will include monitoring variation in care provided against standardized protocols and analyzing the cost and quality variances to drive change.

Five-Year Outcomes: The five- year expected outcome for this project is through the implementation of the cost accounting system, outcome-based payments and quality measures will drive the transformation of the health care delivery system. The outcomes will show cost savings/lowering the cost for care in both impatient and outpatient settings. A goal will be set for cost savings over the five-year period based on the key areas.

Starting Point / Baseline: The starting point/baseline for the redesign of cost containment will be the implementation date of the Medicaid Waiver project: December 11, 2011. This project is implementing a new cost based analysis system to work with our electronic health record system. Therefore, there is no current baseline. The baseline will be established as one of the process improvements in DY 3.

Documentation of the current systems and the selection of the new cost based analysis system will be provided.

Rationale: In order for any health care organization (including Trinity Mother Frances Hospitals & Clinics) to reduce costs (or bend the cost curve), the organization must have access to reliable data. Having access to data, by itself, will not control costs. There must be a process whereby individuals from a variety of backgrounds get together to analyze, interpret, and compare data. This exchange allows for improvement in clinical or business practices that, in turn, leads to cost management. Kaufman Hall, a leading national advisor in health care finance, tells us that the most meaningful cost reduction activities will be data driven and involve standardization of clinical care and elimination of care variation and waste. Trinity Mother Frances Hospitals & Clinics will implement the systems and processes to achieve this goal.

Health care spending for a given population is roughly defined as a function of five basic factors: population needs or morbidity, access to services, propensity to seek services, volume, nature, or intensity of services supplied and/or ordered, and unit cost or price of services.

An accurate cost-accounting methodology is a necessary tool to gauge the impact of quality and efficiency improvement interventions on the cost per unit of service for the delivery of care. Interventions require the investment of numerous resources at many levels of the delivery

system. A cost-accounting system provides the system with the necessary tool to gauge the financial return on investment of interventions.

Establishment of a baseline of costs provides both a starting point for analysis and improvements and a baseline against which to measure success. It is necessary for Trinity Mother Frances Hospitals & Clinics to be able to identify and measure cost containment so that successes can be replicated in other locations and less successful strategies can be changed to reach Trinity Mother Frances Hospitals' & Clinics' cost containment goals.

While Trinity Mother Frances Hospitals & Clinics have maintained a focus on effective and efficient care, the development and implementation of an integrated care model with outcome-based payments is not something that Trinity Mother Frances Hospitals & Clinics have had the financial ability to pursue.

Trinity Mother Frances Hospitals & Clinics will also conduct continuous quality improvement for the project by identifying project impacts, lessons learned, and sharing opportunities to scale all or part of the project, and key challenges associated with expansion of the project.

Project Core Components: All components will be addressed for this project through the milestones and metrics using a workgroup that reaches beyond the silos of finance

A) Implement cost-accounting systems to measure intervention impacts – system to be selected by a team of users
B) Establish a method to measure cost containment – to be developed and implemented by the project team
C) Establish a baseline for cost – to be developed and implemented by the project team
D) Measure cost containment – measurement tools and accountability reporting will be done by the project team and reflected by the milestones and metrics below.

Milestones: P-1, P-2, P-3, P-4, P-9 (DY 3, 4, & 5), I-7 (DY4 & 5)
Metrics: P-1.1, P-2.1, P-3.1, P-4.1, P-9.1 (DY 3 & 4), P-9.2, I-7.1 (DY 4 & 5)

Unique Community Needs:

- CN.6: Efficiency in the effectiveness of health care delivery
- CN.4: High costs due to potentially preventable hospitalizations
- CN.1: Insufficient access to primary specialty care services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project represents a new initiative at MFH. A completely new process for analysis of data will be implemented and costs reports will be developed. A cost accounting system will be selected, tested, and implemented and appropriate targeted analysis will be conducted.

TMF will develop an integrated care model with outcome based payments for its delivery system. Collaborative processes will leverage the unique integration of Trinity Mother Frances hospitals' and over 350 employed physicians and mid-level practitioners.

Related Category 3 Outcome Measure: The expected results of the redesign of the cost containment initiative are to make the provision of health care more efficient and effective by implementing a cost and benefit analysis system.

To demonstrate this, Trinity Mother Frances Healthcare System has selected the Related Category 3 Outcome Measure: OD-5 Cost of Care, IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery.

Reasons/rationale for selecting the outcome measures:
The type of analysis selected is cost benefit analysis and data supporting this will be provided by the data systems. In their Harvard Business Review article from September 2011, Porter and Kaplan noted that "It is a well-known management axiom that what is not measured cannot be managed or improved". By accurately measuring costs, Trinity Mother Frances Healthcare System will be able to manage and improve the effectiveness and efficiency of its provision of health care to low income populations

Relationship to Other Projects and Measures: All of the projects of Mother Frances Hospital complement each other to meet the transformational goals and the three aims of CMS. As Donald Berwick said in Health Affairs, "Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations." We agree and fully support that through our projects for this program: Expand Primary Care, Expand Specialty Care, and Cost Containment.

Having a strong financial base through a redesign for cost containment (094108002.2.1) will ensure the ability of the system to continue to be able to recruit primary care (094108002.1.1) and specialty care providers (094108002.1.2). This project is critical to analyze the information from Category 4 and to relate it to the cost drivers.

Relationships to other Performing Provider Projects' in the RHP1: Only two other performing providers are including redesign of cost containment in their projects (Titus Regional Medical Center and Hopkins County Memorial Hospital). This further raises the importance of this project for the other performing providers for us to serve as a learning tool for them on best practices and elements of implementation analysis. It is our full intention to participate in and lead some of the learning collaborative opportunities to share best practices.

Plan for Learning Collaborative: Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. Mother Frances Hospitals

participates in several learning collaboratives with other hospitals including Health Care Coalition of Texas (hospitals across Texas- all not-for profit) and Texas Care Alliance which includes Baylor, Memorial Herman, and Scott and White. MFH believes in and supports the value of learning collaboratives. MFH supports the learning collaborative plan for Region 1.

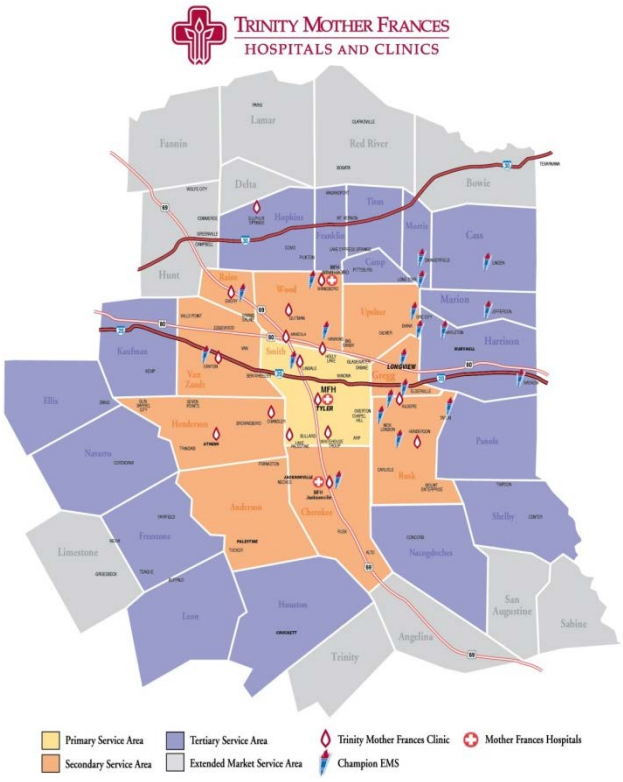
The system pledges to develop, support, participate, and lead the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to have our collaboratives inform others of our experiences and best practices acquired and learn from others in the state. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, Titus Regional, and MFH, have met to discuss the project planning process and selection of projects. Collaborative participants learn best practices, challenges, and solutions.

Project Valuation: The value of this project is based on the fact that it will allow Trinity Mother Frances Healthcare System to accurately measure the costs of its provision health care services. As a result, Trinity Mother Frances Healthcare System will be able to better manage and improve the efficiency and cost effectiveness of its health care services. This will directly impact the community need to increase the efficiency and effective of health care services. This project and its positive results are designed to be inherently sustainable. Implementation of cost accounting will provide the ability to continue measuring the efficiency and cost effectiveness of care. Trinity Mother Frances Healthcare System will continue to measure its cost effectiveness and make improvements into the future. By tracing trends over time and against national best practice benchmarks, this project will allow for meaningful improvements in care patterns, evidence based medicine, and business practices. Improvements become possible across the continuum of care in multiple disciplines. The resulting cost savings will create savings to the health care system and low income patients in NE Texas. Decreasing the cost of health care will drive secondary impacts to the region such as increased use of preventive health care services and use of health care services in an appropriate environment. Having reports that monitor variations in care based upon best practice, will provide information that can be used to drive change. Standardizing processes will create improvements in quality and reduce costs. Without this project, the processes in the hospital across service lines will continue to be done the same way without definitive data clarifying the importance of process changes.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Mother Frances Hospital – Jacksonville and Mother Frances Hospital – Winnsboro. By working as a health care system the impact on recruitment and access to providers is larger and possible for not only the primary service area but also our rural region thus expanding the impact to the RHP#1.

Additionally, the impact of the cost savings projects will make a significant impact on all three hospitals. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformational project be available to the rural hospitals. The lessons learned will be shared across the region.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.



094108002.2.1	2.5.1	2.5.1, A,B,C,D	REDESIGN FOR COST CONTAINMENT	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.3	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Develop/identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions. Metric 1 P-1.1: Metric: Cost-accounting methodology/metric. Baseline: The average annual cost of hospitalization for chosen specific diagnoses for the 9 month period 1/1/12 - 6/30/12. Goal: Documentation of the methodology and metric. Data Source: Cost-accounting system or another administrative, financial or clinical data set.	**Milestone 4 P-4:** Conduct cost analysis. Metric 1 P-4.1: Cost analysis plan or results. Baseline: Comparative report from DY3 to baseline DY2. Goal: Submission of cost analysis plan for targeted improvement. Data Source: Reports from data systems. **Milestone 4 Estimated Incentive Payment $1,299,860** **Milestone 5 P-9:** **Participate in face-to-face learning (i.e. meetings or seminars) at least twice**		**Milestone 6 I-7:** *Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost.* Metric 1 I-7.1: Measure healthcare costs of intervention and gage improvement. Numerator: Total cost for a chosen specific diagnosis. *Denominator: Total patients within a chosen specific diagnosis.* Baseline: Set in DY2. Goal: Improve cost against baseline with an initial goal of $1.2 million. Data Source: Cost accounting	**Milestone 8 I-7:** *Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost.* Metric 1 I-7.1: Measure second healthcare costs of intervention and gage improvement. Numerator: Total cost for a chosen specific diagnosis. Denominator: Total patients within a chosen specific diagnosis Baseline: Set in DY 4 Goal: Improve cost against performance in DY4 to reach $1.5 million in savings.

094108002.2.1	2.5.1	2.5.1, A,B,C,D	REDESIGN FOR COST CONTAINMENT	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.3	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment $794,332 **Milestone 2 P-2:** Establish a baseline for cost. Metric 1 P-2.1: ***Establish a baseline for cost.*** ***a. Submission of baseline data.*** Baseline: Establish a baseline for cost. Goal: Submission of baseline data. Data Source:		**per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.** Metric 1 P-9.1: ***Participate in semi-annual face-to-face meetings or seminars organized by the***	system. **Milestone 6 Estimated Incentive Payment $1,303,639** **Milestone 7 P-9:** **Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for**	Data Source: Cost accounting system. **Milestone 8 Estimated Incentive Payment $1,076,919** **Milestone 9 P-9:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to

094108002.2.1	2.5.1	2.5.1, A,B,C,D	REDESIGN FOR COST CONTAINMENT	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	**094108002.3.3**	**IT-5.1**	**Improved cost savings: Demonstrate cost savings in care delivery**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Cost-accounting system or another administrative, financial, or clinical data set. **Milestone 2 Estimated Incentive Payment $794,332** **Milestone 3 P-3:** **Implement the cost-accounting methodology and related systems to measure intervention impacts.** Metric 1 P-3.1: Cost-accounting system. *Documentation of adoption, installation, upgrade and/or interface of technology, and/or*	***RHP.*** Baseline: 0- No meetings held. Goal: 1) Participate 100%. 2) Initiate leadership group for presenting and mentoring on best practices. Data Source: Documentation of semiannual meetings including, meeting agenda, slides from presentations, and/or meeting notes. **Milestone 5 Estimated Incentive Payment $1,299,861**		**performance). Each participating provider should publicly commit to implementing these improvements.** Metric 1 P-9.1: ***Participate in semi-annual face-to-face meetings or seminars organized by the RHP.*** Baseline: 0- No meetings held. Goal: 1) Participate 100%. 2) Initiate leadership group for presenting and mentoring on best practices. Data Source: Documentation of semiannual meetings including, meeting agenda,	implementing these improvements. Metric 1 P-9.2: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline: 0 - New process. Goal: Implement an initiative. *Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting.*

094108002.2.1	2.5.1	2.5.1, A,B,C,D	REDESIGN FOR COST CONTAINMENT	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.3	IT-5.1	**Improved cost savings: Demonstrate cost savings in care delivery**	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
implementation of system using existing technology. Baseline: System not installed or update completed. Goal: Adoption, installation, upgrade, and/or interface of technology, and/or implementation of system using existing technology. Data Source: Cost Accounting System. **Milestone 3 Estimated Incentive Payment $794,332**			slides from presentations, and/or meeting notes. **Milestone 7 Estimated Incentive Payment $1,303,639**	**Milestone 9 Estimated Incentive Payment $1,076,919**
Year 2 Estimated Milestone Bundle Amount: **$2,382,996**		Year 3 Estimated Milestone Bundle Amount: **$2,599,721**	Year 4 Estimated Milestone Bundle Amount: **$2,607,278**	Year 5 Estimated Milestone Bundle Amount: **$2,153,838**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $9,743,833**				

Project Option: 2.9.1 Patient Navigation for Women with Breast Cancer
Project Identifier: 094108002.2.2 (Pass 2)
Performing Provider Name/TPI: Mother Frances Hospital 094108002

Project Abstract

Provider Description: Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. Mother Frances Hospital-Tyler had almost 100,000 inpatient and outpatient encounters from Medicaid and self pay on an annual basis. This represents about 20% of the hospital's total volume and the costs to treat these patients were over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances.

Intervention(s): This project will implement a patient navigator dedicated to guiding patients with breast cancer through their care needs. The interventions will include but not be limited to referral to primary care medical home, specialty care referral for disenfranchised or medically complex patients, and education on appropriate level of care needed and medical instructions, and follow-up with patients.

Need for the Project: Currently, we do not use patient navigators for breast cancer patients. Women who are diagnosed with breast cancer have difficulty navigating the health care system. Unfortunately, the average time for a surgery referral appointment is 30 days which delays appropriate evaluations and care plans.

Target Population: We anticipate program enrollment to be 200 patients in DY3, 225 patients in DY4, and 250 patients in DY5. The target population are patients seeking services need specialist referral care, primary care provider, specialized testing or financial assistance. Approximately, 4% of the 43,000 are Medicaid with another 2% self pay.

Category 2 Expended Patient Benefits: Patients will receive navigator support, guidance, and direction in maneuvering through the health care system. We anticipate program enrollment

over the 3 years to be 200 patients in DY3, 225 patients in DY4, and 250 patients in DY5 for a total of 675 patients to be served.

Category 3 Outcomes: IT-6.1 Percent improvement over baseline of patient satisfaction scores. Our goal is to reduce the waiting time to see a specialist for surgery from 30 days to 14 days. Survey tool to be used is CG-CAPHS.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Trinity Clinic and ContinueCARE Hospital. By working as a health care system the impact on recruitment and access to providers is made possible for not only access to pediatric telemedicine services in the ED but also to improve care transitions and provide patient navigation services. Again, these programs will impact patient care across the RHP#1 and for both inpatient and outpatient services.

Additionally, the impact of the cost savings projects will make a significant impact on these two entities also, even though their funding was not directly applied to that project. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformable project be available to the rural hospitals and out-patient services.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

Project Narrative

Project Description: Trinity Mother Frances Hospital and Clinics proposes to provide navigation services to targeted women who have been identified with breast cancer and are at high risk of disconnect from the institutionalized health care. The project would improve access to care by utilizing a patient navigator for Medicaid and indigent women as well as others seen and who have been diagnosed or are in the process of diagnoses with breast cancer but have not received a treatment plan

Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. . Mother Frances Hospital-Tyler had almost 100,000 inpatient and outpatient encounters from Medicaid and self pay on an annual basis. This represents about 20% of the hospital's total volume and the costs to treat these patients were over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances.

The patient navigator will help and support these patients to move through the continuum of health care services. This patient navigator will ensure that patients receive and are directed to a primary care provider in a medical home to help with medical needs if necessary. This will include education sessions on options and telephone support for after hour care.

The navigator will engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through the integrated health care delivery systems. The navigator will coordinate timely services when needed with smooth transitions between health care settings. And additionally will provide community education related to Breast Care Services available to women in East Texas.

Over 43,000 patients are served annually just through the Ross Breast Center and approximately 300 new breast cancers are detected in patients in our facilities each year. That includes screenings at five permanent sites with digital equipment serving Smith and Van Zandt Counties. A mobile unit with a digital screening equipment travels to 15 sites in 11 counties throughout the year.

Goals and Relationship to Regional Goals: The goal of this project is to use patient navigators to provide enhanced care coordination, community outreach, social support, and culturally competent care to vulnerable and/or high risk women.

Project Goals:

- Target 675 new women who are at high risk for breast cancer issues during the project
- Assign a patient navigator to ensure their care is coordinated
- Reduce time between diagnosis and surgery referral visit from 30 days to 14 days.
- Establish a new community high risk education/outreach program

In the era of reform and reduced reimbursements, hospitals and health systems face an imperative to deliver high quality services with broad access for all patients including those who need assistance with using multiple areas of the system from the emergency department, primary care, and specialty care. Access to a surgery or oncologist visit is an element that will reduce cost if it is done on a timelier basis.

This project meets the following regional goals:

- Address the gaps in access to care –both physical and behavioral health sciences

- Improving the patient experience of care – including quality and satisfaction
- Improving the health of populations
- Reducing the per capita cost of health care by improving the time it takes to get a referral

Why establish a pilot project addressing the need for a patient care navigator program? The need to implement and strive to meet the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. With the expansion of primary care and specialty care it is imperative to educate and direct patients to the most appropriate care setting into early treatment supported by a health care team who will secure their primary care services or other specialists as needed. Patient navigators will provide the structure to target the population, develop training and processes to direct patients and provide a support system for their care that should result in reduced costs within the system and to patients through early treatment and avoidance of later stage disease.

For the purposes of this project one (1) patient navigator will be hired to direct and coordinate the care of 675 patients over the period of the project averaging 200 – 250 per year and develop a community outreach program.

Challenges: Trinity Mother Frances Hospitals & Clinics have not had a medical record system that provided real time information for both primary care and specialists. With the implementation of our new Connect Care System, patients, providers, and all hospital departments will have access to information. This alone however will not address the success and timeliness of moving a patient from diagnosis to treatment of breast cancer – the Patient Navigator will still experience the challenge of managing the underserved population (those with no insurance) and those who dismiss the diagnosis (fear). The Navigator will be an advocate for uninsured women who have used Komen Grant funding for screening and are now faced with surgery and adjunct treatment which will require knowledge of available funding and coordination with the patient's health care team.

5-Year Expected Outcomes for Provider and Patients: The five- year expected outcome for this project is to test the implementation of a patient navigator program that lays the foundation for the use of directed coordinated care that will improve the access to a surgeon from 30 to 14 days for their first visit, implementation of a support process for patients, and a resource for a strong and easy continuum of care throughout all care settings. The community outreach will improve the opportunity for screening exams and will result by year 5 in an increase of 400 new screening exams per year for the period of the waiver. And over 675 patients will be navigated through the system for services for breast cancer.

Starting Point / Baseline: The starting point/baseline for the development of the pilot project for patient navigator will be the implementation date of the Medicaid Waiver project: September 30, 2012. This project is hiring a new provider to implement the project. Therefore,

the current baseline is zero for patients in the target project. The baseline will be established as one of the process improvements in DY 3 with a target of 200 patients and by DY 4 a total of 225 patients, and DY 5: 250 patients for a total of 675.

Documentation of the current systems and the selection of the new navigator will be provided

Rationale: Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organization and other components of the health care system. Services by patient's navigators may include such things as:

- Provides education information and support to all women concerned about their breast health
- Services as an educational resource for families and the patient to answer their questions address their fears during the breast cancer experience
- Facilitates recommendations for patient care to help ensure patient compliance and understanding
- Manages the challenge of cost reduction, a pivotal driving force in healthcare
- Acknowledges cost-restraint mandates, such as early discharge from hospitals by enabling patients and empowering them to understand their care processes
- Provides patient self-care skills in response to reduce access to unnecessary visits to primary care provider or emergency department
- Provides professional guidance in coordination, execution and evaluation of their health care treatment plans
- Facilitating communication among patients, family members,
- Coordinating care among providers
- Ensuring that appropriate medical records are available at medical appointments
- Ensuring access to clinical care with primary care providers

While there is no set education requirement for a patient navigator to be successful, they should be:

- Compassionate, sensitive, culturally attuned to the people and community being served
- Knowledgeable about the environment and healthcare system
- Connected with critical decision makers inside the system

Assessing the needs and gaps as a first step will ensure that the qualities and processes are included for the targeted population. The information tools developed to be shared and used by all segments of care will be important and will require input from inpatient, emergency care, and outpatient care leaders and providers.

Our goal is to provide an outpatient setting for care for a target population which will result in more effective care, higher use of a primary care medical home, and lower number of patients seeking care at a higher level of cost. Key elements will include:

1. Assess to identify high-risk patients (genetic, physical, psychological and social)
2. Coordinate care with other team members
3. Provide education and support for patient and family

4. Monitor patients total response to care optimum outcomes
5. Improve patient satisfaction scores (studies show higher satisfaction when a navigator is involved in a cancer patient's treatment plan
6. Improve cancer survival rate by supporting access to treatment

Project Components: All required components of the project will be addressed by the project and are needed in the region:

A) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

B) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

C) Connect patients to primary and preventive care.

D) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

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

Milestones: P-2, P-3 (DY 3 & 4), P-5, P-8 (DY 4 & 5), I-6(DY 4 & 5), I-9
Metrics: P-2.1, P-3.1 (DY3 & 4), P-5.1, P-8.1 (DY 4 & 5), I-6.4 (DY 4 & 5), I-9.2

Unique Community Needs:

- CN.1: Insufficient access to primary and specialty care services
- CN.3: High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
- CN.4: High costs due to potentially preventable hospitalizations
- CN.6: Efficiency in the effectiveness of health care delivery

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: There is no program like this in the region to support breast cancer patients. It supports the need identified as avoiding delay of treatment thereby decreasing likelihood of mortality or costly hospitalization due to advanced disease. The patient navigator for Ross Breast Center will use protocols in the emergency department, if they present there, to shift patients to primary care and medical homes thus decreasing cost of care due to delay of diagnosis. Additionally, the specialist being hired will track these patients to ensure follow up and provide access for screening and diagnostic testing and other specialists as needed, in coordination with primary care provider.

This is a new initiative in our delivery system that we believe will improve the outcomes for the new breast cancer patients and improves patient satisfaction. The project will improve the cancer survival rate by supporting access to screening for high risk individuals

Delivery System Solution: Trinity Mother Frances Hospitals and Clinics leadership will embark on the development of an integrated care model with support for a target population. This collaborative process will include every area from the screening to surgery and the support of a primary care provider or support group. By hiring a patient navigator to develop and implement this program, patient care and outcomes will be improved.

Related Category 3 Outcome Measure: OD-6 Patient Satisfaction, IT-6.1 Percent Improvement over baseline of patient satisfaction scores using the CG-CAPHS survey.

Reasons/rationale for selecting the outcome measures:
Documentation of the number of surgical referrals, and visits, and community awareness programs will be provided by system administration documents to ensure enhanced services are being provided in a timelier manner. Understanding the strengths and needs for improvement by receiving patient feedback allows providers and staff to better understand how to tailor care delivery to meet their patient's needs.

We will utilize patient satisfaction surveys to provide feedback regarding the ease of accessing care in our facilities and to monitor satisfaction over time. Our goal will be to identify predictors of patient satisfaction. This project will require the implementation of the CG-CAPHS satisfaction survey for this project.

Relationship to Other Projects and Measures: All of the projects of Mother Frances Hospital complement each other to meet the transformational goals and the three aims of CMS. As Donald Berwick said in Health Affairs, "Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations." We agree and fully support that through our projects for this program: Expand Primary Care, Patient Navigation Program for Ross Breast Center, Expand Specialty Care, and Cost Containment.

Expanding primary care and specialty care will ensure the opportunity for appropriate referrals for patient diagnosed with cancer. This project will also require the support and work with other oncology providers in the area.

Having a strong financial base through a redesign for cost containment (094108002.2.1) will ensure the ability of the system to continue to be able to recruit primary care (094108002.1.1) and specialty care providers (094108002.1.2). This project is critical to analyze the information from Category 4 and to relate it to the cost drivers.

Relationships to other Performing Provider Projects' in the RHP1: This project for breast cancer patients will include the only medical homes in the region and the largest breast cancer center in the region. TMFHC will participate and share information with others in the region.

Others in the region that will be engaged include but are not limited to Hopkins County, Hunt County, Titus Regional, University Physicians, and Good Shepherd.

Plan for Learning Collaborative: TMFHC will participate in the RHP-wide learning collaborative with other providers who are engaged in implementing patient navigation projects. Learning collaborative is essential to the success of high quality health systems that achieve the highest level of performance. Mother Frances Hospitals participates in several learning collaborative with other hospitals including Health Care Coalition of Texas (hospitals across Texas- all not-for profit) and Texas Care Alliance which includes Baylor, and Scott and White. MFH believes in and supports the value of learning collaborative. MFH supports the learning collaborative plan for Region 1.

The system pledges to develop, support, participate, and lead the effort if asked to form learning collaborative to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region.

Project Valuation: The value of this project is based on the fact that it will allow Trinity Mother Frances Health System to appropriately provide care for patients' at the most appropriate and cost effective place. As a result, Trinity Mother Frances Health System will be able to better manage and improve the outcomes for the patients and improve patient satisfaction. This will directly impact the community need to increase the efficiency and effective of health care services. This project and its positive results are designed to be inherently sustainable. Trinity Mother Frances Health System will continue to provide patient navigation services and will look for opportunities to expand those services and financial support becomes available. By tracing trends over time and against national best practice benchmarks, this project will allow for meaningful improvements in care patterns, evidence based medicine, and business practices. Improvements become possible across the continuum of care in multiple disciplines. The resulting cost savings will create savings to the health care system and low income patients in NE Texas. Access to appropriate care and use of health care services outside of the emergency department will result in decreasing the cost of health care will drive secondary impacts to the region.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Trinity Clinic and ContinueCARE Hospital. By working as a health care system the impact on recruitment and access to providers is made possible for not only access to pediatric telemedicine services in the ED but also to improve care transitions and provide patient navigation services. Again, these programs will impact patient care across the RHP#1 and for both inpatient and outpatient services.

Additionally, the impact of the cost savings projects will make a significant impact on these two entities also, even though their funding was not directly applied to that project. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformable project be available to the rural hospitals and out-patient services.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

094108002.2.2	2.9.1	2.9.1, A,B,C,D,E	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-2: Establish a health care navigation program to provide support to patient populations who are at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 P-2.1: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. a. Workforce development plan for patient navigator recruitment, training and education	**Milestone 2 P-3:** Provide care management/navigation services to targeted patients. Metric 1 P-3.1: Increase in the number or percent of targeted patients enrolled in the program a. Numerator: Number of targeted patients enrolled in the program b. Denominator: Total number of targeted patients identified Baseline: 0- new program, no patients enrolled. Goal: Enroll 200 patients. Data Source: Enrollment reports **Milestone 2 Estimated**	**Milestone 4 P-3:** Provide care management/navigation services to targeted patients. Metric 1 P-3.1: Increase in the number or percent of targeted patients enrolled in the program a. Numerator: Number of targeted patients enrolled in the program b. Denominator: Total number of targeted patients identified Baseline: Patients enrolled in DY3. Goal: Enroll 225 new patients. Data Source: Enrollment reports **Milestone 4 Estimated**	**Milestone 7 P-3:** Provide care management/navigation services to targeted patients. Metric 1 P-3.1: Increase in the number or percent of targeted patients enrolled in the program a. Numerator: Number of targeted patients enrolled in the program b. Denominator: Total number of targeted patients identified Baseline: Patients enrolled in DY4 Goal: Enroll 250 new patients. Data Source: Enrollment reports **Milestone 7 Estimated**

094108002.2.2	2.9.1	2.9.1, A,B,C,D,E	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline: New program/no employees Goal: Hire one navigator; train one navigator to serve a margin of 200 - 250 patients Data Source: Patient navigation program materials and database, EHR **Milestone 1 Estimated Incentive Payment $340,656**	**Incentive Payment $190,086** **Milestone 3 P-5:** Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. Especially for disenfranchised or medically complex patients, navigation is about guiding people through and across the HC system, from provider to provider, ensuring they can get to an make multiple appointments, get prescriptions filled, access to community services for people with special needs (such as getting cancer patients access to support groups), etc. the		**Incentive Payment $129,480** **Milestone 5 P-8:** **Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these**	**Incentive Payment $80,797** **Milestone 8 I-6:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 I-6.4: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment a. Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. b. Denominator: Number of patients without a

094108002.2.2	2.9.1	2.9.1, A,B,C,D,E	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	**094108002.3.5**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	patient navigator represents the liaison between primary, secondary, tertiary and quaternary health care. Metric 1 P-5.1: Collect and report on all the types of patient navigator services provided. Baseline: **0-New program.** Goal: Complete first report. Data Source: Collect and report on all types of patient navigator services provided. **Milestone 3 Estimated Incentive Payment $190,087**		**improvements.** Metric 1 P-8.1: ***Participate in semi-annual face-to-face meetings or seminars organized by the RHP.*** Baseline: 0- No meetings held. Goal: 1) Participate 100%. 2) Initiate leadership group for presenting and mentoring on best practices. Data Source: Documentation of semiannual meetings including, meeting agenda, slides from presentations, and/or meeting notes. **Milestone 5 Estimated Incentive Payment $129,481**	PCP documented in their medical record using the care navigation program. Baseline: -80% referred in DY4 Goal: Refer 90% of non-urgent patients Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. **Milestone 8 Estimated Incentive Payment $80,797** **Milestone 9 P-8:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and

094108002.2.2	2.9.1	2.9.1, A,B,C,D,E	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 6 I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 I-6.4: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment a. Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. b. Denominator: Number of patients without a PCP documented in	the RHP to promote collaborative learning around shared or similar projects. **At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.** Metric 1 P-8.1: ***Participate in semi-annual face-to-face meetings or seminars organized by the RHP.***

094108002.2.2	2.9.1	2.9.1, A,B,C,D,E	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	**094108002.3.5**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			their medical record using the care navigation program. Baseline: Set in DY3 Goal: Refer 80% of non-urgent patients above baseline in DY3. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. **Milestone 6 Estimated Incentive Payment $129,481**	Baseline: 100% participation from DY 4. Goal: 1) Participate 100%. 2) Initiate leadership group for presenting and mentoring on best practices. Data Source: Documentation of semiannual meetings including, meeting agenda, slides from presentations, and/or meeting notes. **Milestone 9 Estimated Incentive Payment $80,797** **Milestone10 9 I-9:** Additional outcome metrics (to be specified by Performing Provider based upon target population and project rationale).

094108002.2.2	2.9.1	2.9.1, A,B,C,D,E	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			Metric 1 I-9.2: Improved compliance with recommended care regimens. a. Numerator: % compliance with (recommended care regimen) (TBD by provider) of patients participating in Navigator program. b. Denominator: % compliance with (recommended care regimen) (TBD by provider) of all patients. Baseline: 0- New program. Goal: 50% compliance. Data Source: EHR, claims **Milestone 10 Estimated Incentive Payment $80,796**

094108002.2.2	2.9.1	2.9.1, A,B,C,D,E	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Mother Frances Hospital				094108002
Related Category 3 Outcome Measure(s):	094108002.3.5	IT-6.1	**Percent improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: **$340,656**		Year 3 Estimated Milestone Bundle Amount: **$380,173**	Year 4 Estimated Milestone Bundle Amount: **$388,442**	Year 5 Estimated Milestone Bundle Amount: **$323,187**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: **$1,432,458**				

Project Option: 2.12.1. Implement/Expand Care Transition Programs
Project Identifier: 094108002.2.3 (Pass 2)
Performing Provider Name/TPI: Mother Frances Hospital 094108002

Project Abstract

Provider Description: Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. Mother Frances Hospital-Tyler had almost 100,000 inpatient and outpatient encounters from Medicaid and self pay on an annual basis. This represents about 20% of the hospital's total volume and the costs to treat these patients were over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances.

Intervention(s): The goal of this project is to implement improvements in care transitions and coordination of care from impatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. Safe, effective, and efficient care transitions can reduce the risk of potentially preventable readmissions but will require cooperation among providers of medical services, social services, and support services into eh community and in long-term care facilities.

Need for the Project: Currently, we do not have anyone who is providing this service within any of our facilities. It is expected this will set the benchmark for expansion across the system to improve the rate of potentially preventable readmissions.

Target Population: We anticipate that 200 – 250 patients will be targeted annually. The target population is our inpatients who are ready for discharge and are at risk for potentially preventable readmissions. Approximately 20% will be Medicaid and self pay.

Category 2 Expended Patient Benefits: The project seeks to provide 675 targeted patients with high level of tracking of care and support in DY 3: 200, DY4: 225, and DY5: 250 patients. Of the patients served it is anticipated that 20% will be Medicaid, indigent, or self pay.

Category 3 Outcomes: IT-3.1 All cause – 30 day readmission rate-NQF 1789. Our goal is to reduce the readmission rate over the baseline.

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Trinity Clinic and ContinueCARE Hospital. By working as a health care system the impact on recruitment and access to providers is made possible for not only access to pediatric telemedicine services in the ED but also to improve care transitions and provide patient navigation services. Again, these programs will impact patient care across the RHP#1 for both inpatient and outpatient services.

Additionally, the impact of the cost savings projects will make a significant impact on these two entities also, even though their funding was not directly applied to that project. Only by collaborating with a major acute care hospital with over 500,000 patient visits per year will such a transformable project be available to the rural hospitals and out-patient services.

Clearly, all parties have positive impacts on these and all projects of Mother Frances Hospital regardless of who the primary collaborators are with at any time.

Project Narrative

Project Description: The purpose of this project is to address the growing number of potentially preventable readmissions through a coordination of care prior to discharge and thereafter with a collaboration of caregivers. It will require a multidisciplinary team approach to decision making and strong leadership across the continuum of care.

Trinity Mother Frances Hospitals and Clinics serve more than 1.2 million people in a 27-county area. Trinity Clinic is the area's preferred multispecialty medical group, with over 350 physicians and mid-level providers representing 39 specialties in 36 clinic locations serving east Texas. Mother Frances Hospital is a 474 bed acute care facility providing highly specialized services including Level III neonatal ICU, neurosciences, critical care, and emergency care and trauma. This includes Region 1's only dedicated heart hospital. Both our MFH-Jacksonville and Winnsboro are critical care access hospitals with 25 beds each. MFH has a long term hospital with 51 beds and a rehabilitation facility with 74. This bed capacity for acute care and specialty care needs is close to 675. . Mother Frances Hospital-Tyler had almost 100,000 inpatient and outpatient encounters from Medicaid and self pay on an annual basis. This represents about 20% of the hospital's total volume and the costs to treat these patients were over $65 million.

MFH-Tyler is the primary referral site for Palestine Regional Medical Center (Palestine), Titus Regional Medical Center (Mount Pleasant), and Hopkins Medical Center (Sulphur Springs). Significant referrals are received from Paris and Kilgore. Tyler Family Circle of Care are three clinics that until October 1, 2012, were provider based clinics of TMF-Tyler. These clinics see

about 50,000 patient's visits a year and 88% are Medicaid and 67% of the births of MFH are from the OB clinic. All clinics are financially supported by Trinity Mother Frances.

For the block grant purposes, Mother Frances Hospital was identified as a Medicaid safety net hospital with the largest percent for the region.

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care –for example from hospital to home or nursing home or from facility to home have been shown to be prone to error. Safe, effective, and efficient care transitions can reduce the risk of potentially preventable readmissions but will require cooperation among providers of medical services, social services, and support services into eh community and in long--term care facilities.

Utilizing a new health care professional to direct the care transition project will allow a focus on a target population that are at risk to be seen over and over again through readmissions to the hospital. The new staff person will be coordinating care givers, educating family, and working to ensure the patient's health needs are being met.

The care transition program will help and support these patients to navigate through the continuum of health care services. This project will integrate information systems so that continuity of care for patients is enabled and that a system is developed to identify patients being discharged who are potentially at risk of needing acute care services within 30 – 60 days.

Implementing discharge planning programs and post discharge support programs are critical to the success of this project and must be managed with a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.

Why establish a pilot project addressing the need for a care transition programs? The need to implement and strive to meet the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care is a goal of our health system and needed to meet the changes in health care delivery requirements.

To be more flexible and able to react to changes in the delivery system, a clear and concise understanding of how to move patients to different levels of care with a focus on improved outcomes for the patient is essential. This project will provide the structure to target the population, develop training and processes to re-direct patients and provide a support system for their care that should result in reduced costs within the system and to patients and their payer systems. Key to this project is a collaboration of providers and protocols being established and implemented consistently.

Goals and Relationship to Regional Goals: The goals of this project interact with the regional goals to support the Texas Healthcare Transformation and Quality Improvement Program which is designed to improve access to care and the health of patients and families they serve.

Project Goals:

- Implement improvements in care transitions and coordination of care from impatient to outpatient, post-acute care, and home settings
- Prevent increased health care costs
- Prevent hospital readmissions
- Develop multidisciplinary team for all aspect of the project

This project meets the following regional goals:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of population; and
- Reducing the per capita cost of health care
- Addressing gaps in access to care in multiple areas

Challenges:

North East Texas has been and continues to be one of the largest areas for the senior population. Tyler is in fact, a certified retirement community. With this aging population often comes a lack of understanding of their health issues, difficulty in gaining compliance with health recommendations, lack of family support to assist with the patient's care and a general lack of ability to make medical decisions. With the implementation of a care transition program the additional step of personalized support for a group of patients will be tested for patient outcomes and access to appropriate care at the right time in the right place resulting in lowering the number of potentially preventable readmissions.

Five-Year Outcomes: The five- year expected outcome for this project is to test the implementation of a patient navigator program that lays the foundation for the use of directed coordinated care for at risk patients who have multiple health care issues and are at high risk for readmission to the hospital.

The outcomes should show a decline in the readmission rate over the baseline as established in DY 3 and greater coordination between caregivers.

Starting Point / Baseline: The starting point/baseline for the development of the pilot project for care transition project will be the implementation date of the Medicaid Waiver project: September 30, 2012. This project is hiring a new coordinator to implement the program. Therefore, there is no current baseline.

Documentation of the current systems and the development of the program and direction will be provided

Rationale:
When a patient's transition is less than optimal, the repercussions can be far-reaching – hospital readmission, an adverse medical event, and even mortality. Without sufficient information and a understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from hospital to home or nursing home of from facility to home and community based services.

Assessing the needs and gaps as a first step will ensure that the qualities and processes are included for the targeted population. The information tools developed will be shared and used by all segments of care and will require input from a multiple disciplinary team.

Project Components:
The goal is to work with a pilot target population of 675 patients over the four year period and to track and manage those patient's care to reduce the potentially readmission rate.
All core components of this project will be addressed throughout the project:

A) Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.).
B) Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews.
C) Integrate information systems so that continuity of care for patients is enabled
D) Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days
E) Implement discharge planning program and post discharge support program
F) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
G) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

A multi-disciplinary team from TMF and outside providers and community groups impacted will be working on all the core components and will drive the milestone and metric implementation.
Milestones: P-1, P-2, P-4, P-5, P-7, P-12 (DY 3 & 4), I-10, I-14 (DY 4 & 5)
Metrics: P-1.1, P-2.1, P-4.1, P-5.1, P-7.1

Unique Community Needs:

- CN.6: Efficiency in the effectiveness of health care delivery
- CN.4 High costs due to potentially preventable hospitalizations
- CN.5 Inappropriate emergency room utilization.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Currently, a care transitions program does not exist within the Trinity Mother Frances Health System. Therefore, this is a new initiative.

Delivery System Solution: Trinity Mother Frances Hospitals & Clinics leadership will embark on the development of an integrated care model with support for a target population. Collaborative processes will leverage the unique integration of Trinity Mother Frances hospitals' and over 350 employed physicians and mid levels.

For the purposes of this project one (1) care transition leader will be hired to direct and coordinate the care of 675 patients during the project.

Related Category 3 Outcome Measure:
To demonstrate this, Trinity Mother Frances Healthcare System has selected the Related Category 3 Outcome Measure: OD-3; Potentially Preventable Readmission-30 day readmission rates (PPRs) and improvement target,; 3.1 all cause 30 day readmission rate – NQF 1789.

Reasons/rationale for selecting the outcome measures:
Potentially preventable readmissions (PPR's) are a key target for improvement over the next four years to improve the health of our patients and support the elements of the project to implement care transition teams.

Relationship to Other Projects and Measures: All of the projects of Mother Frances Hospital complement each other to meet the transformational goals and the three aims of CMS. As Donald Berwick said in Health Affairs, "Work to improve site-specific care for individuals should expand and thrive. In our view, however, the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations." We agree and fully support that through our projects for this program: Expand Primary Care, Expand Specialty Care, Cost Containment, TeleMedicine, and Patient Navigation.

While there are other projects in the region that will be addressing portion of this project, we will work with all the entities to ensure that information is being shared and that best practices are implemented. A clear understanding of the challenges and the outcomes of this project will be presented.

Relationships to other Performing Provider Projects' in the RHP1: The pilot project will includes the only medical homes, Trinity Clinic, in the region and the largest emergency department in Smith County and the second largest in the region and thus is not duplicative of others in the region. Additionally, we will have collaborations with other hospitals in the region to share information on best practices and issues they are facing in implementation and improvement in outcomes will allow all of us to improve care for our patients and show cost savings. As with all projects, TMFHC will participate and share information with others in the region. It will be essential to work hand in hand with all the providers who are performing projects but also to bring in to the process those other providers of care for this project who are not performing providers to share and understand the processes.

Both University Physicians and Hunt Medical Center are also doing a transition project. TMF will work closely with both facilities.

Plan for Learning Collaborative: TMFHC will participate in the RHP-wide learning collaborative with other providers who are engaged in implementing care transition programs. Learning collaborative is essential to the success of high quality health systems that achieve the highest level of performance. Mother Frances Hospitals participates in several learning collaborative with other hospitals including Health Care Coalition of Texas (hospitals across Texas- all not-for profit) and Texas Care Alliance which includes Baylor, and Scott and White. MFH believes in and supports the value of learning collaborative. MFH supports the learning collaborative plan for Region 1.

The system pledges to develop, support, participate, and lead the effort if asked to form learning collaborative to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, Titus Regional, and MFH, have met to discuss the project planning process and selection of projects. Collaborative participants learn best practices, challenges, and solutions.

Project Valuation: The value of this project is based on the fact that it will allow Trinity Mother Frances Healthcare System to appropriately provide care for patients' at the most appropriate and cost effective place. As a result, Trinity Mother Frances Healthcare System will be able to better manage and improve the outcomes for the patients and improve potentially preventable readmission – 30 day all causes. This will directly impact the community need to increase the efficiency and effectiveness of health care services, high costs due to readmissions, and inappropriate emergency room utilization. This project and its positive results are designed to be inherently sustainable. Trinity Mother Frances Healthcare System will continue to provide care transition services and will look for opportunities to expand those services when financial

support becomes available. By tracing trends over time and against national best practice benchmarks, this project will allow for meaningful improvements in care patterns, evidence based medicine, and business practices. Improvements become possible across the continuum of care in multiple disciplines. The resulting cost savings will create savings to the health care system and low income patients in NE Texas. Access to appropriate care and use of health care services outside of the emergency department will result in decreasing the cost of health care will drive secondary impacts to the region such as increased use of preventive health care services.

Coleman EA. "Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Care Needs." Journal of the American Geriatrics Society (2003) 51:549-555
Rittenhouse D, Shortell S, et al. "Improving Chronic Illness Care: Findings from a National Study of Care Management Processes in Large Physician Practices." Medical Care Research and Review Journal (2010) 67(3): 301-320
Coleman, E., Parry, C., et. al. "The Care Transitions Intervention: a patient centered approach to ensuring effective transfers between sites of geriatric care." Home Health Care Serv Q

Project Collaboration: Mother Frances Hospital – Tyler collaborated with Trinity Clinic and ContinueCARE Hospital. By working as a health care system the impact on recruitment and access to providers is made possible for not only access to pediatric telemedicine services in the ED but also to improve care transitions and provide patient navigation services. Again, these programs will impact patient care across the RHP#1 for both inpatient and outpatient services.

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094108002.2.3	2.12.1	2.12.1, A,B,C,D,E, F, G	DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS	
Mother Frances Hospital				**094108002**
Related Category 3 Outcome Measure(s):	**094108002.3.6**	**IT-3.1**	**All cause – 30 day readmission rate- NQF 1789**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1: Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions Metric 1 P-1.1: Care transitions protocols Baseline: New project, no current evidence-based protocols established Goal: Submit protocols Data Source: Submission of protocols, Care transitions program materials **Milestone 1 Estimated**	**Milestone 4 P-5:** Using a validated risk assessment tool, create a patient identification system Metric 1 P-5.1: Patient stratification system Baseline: New program, no current patient identification system Goal: Establish patient identification system Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization of report findings **Milestone 4 Estimated Incentive Payment $95,043** **Milestone 5 P-7:** Develop a staffing and implementation plan to accomplish the	**Milestone 8 P-12:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements Metric 1 P-12.1: Participate in semi-annual face-to-face meetings or seminars	**Milestone 11 I-14:** Implement standard care transition processes in specified patient populations Metric 1 I-14.1: Measure adherence to processes a. Numerator: Number of patients in defined population receiving care according to standard protocol b. Denominator: Number of population patients discharged Baseline: 225 patients in DY4 Goal: 250 new patients in the program Data Source: Hospital administrative data and the

094108002.2.3	2.12.1	2.12.1, A,B,C,D,E, F, G	DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS	
Mother Frances Hospital				**094108002**
Related Category 3 Outcome Measure(s):	**094108002.3.6**	**IT-3.1**	**All cause – 30 day readmission rate- NQF 1789**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment $113,552 **Milestone 2 P-2:** Implement standardized care transition processes <u>Metric 1</u> P-2.1: Care transitions policies and procedures Baseline: 0- New project. Goal: Implement standardized care transition processes Data Source: Care transitions program materials **Milestone 2 Estimated Incentive Payment $113,552** **Milestone 3 P-4:** Conduct an assessment and establish linkages with	goals/objectives of the care transitions program <u>Metric 1</u> P-7.1: Documentation of the staffing plan Baseline: No staffing or implementation plan Goal: Hire staff and develop plan Data Source: Staffing and implementation plan **Milestone 5 Estimated Incentive Payment $95,043** **Milestone 6 P-12:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and		organized by the RHP Baseline: Participation in DY3 Goal: Participate in 100% of meetings Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting **Milestone 8 Estimated Incentive Payment $ 129,480** **Milestone 9 I-10:** Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient	patient medical record **Milestone 11 Estimated Incentive Payment $323,187**

094108002.2.3	2.12.1	2.12.1, A,B,C,D,E, F, G	DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS	
Mother Frances Hospital				**094108002**
Related Category 3 Outcome Measure(s):	**094108002.3.6**	**IT-3.1**	**All cause – 30 day readmission rate- NQF 1789**	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
community-based organizations to create a support network for targeted patients post-discharge Metric 1 P-4.1: Care transitions assessment Baseline: No assessment Goal: Submission of care transitions assessment and resource planning documents Data Source: Care transitions assessment and resource planning documents **Milestone 3 Estimated Incentive Payment $113,552**		the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements Metric 1 P-12.1: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline: No meetings Goal: Participate in 100% of meetings	characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions Metric 1 I-10.1: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions Baseline: No report Goal: Report completed Data Source: Registry or EHR report/analysis **Milestone 9 Estimated**	

094108002.2.3	2.12.1	2.12.1, A,B,C,D,E, F, G	DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS	
Mother Frances Hospital				**094108002**
Related Category 3 Outcome Measure(s):	**094108002.3.6**	**IT-3.1**	**All cause – 30 day readmission rate- NQF 1789**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting **Milestone 6 Estimated Incentive Payment $95,043** **Milestone 7 I-14:** Implement standard care transition processes in specified patient populations Metric 1 I-14.1: Measure adherence to processes a. Numerator: Number of patients in defined		**Incentive Payment $129,481** **Milestone 10 I-14:** Implement standard care transition processes in specified patient populations Metric 1 I-14.1: Measure adherence to processes c. Numerator: Number of patients in defined population receiving care according to standard protocol d. Denominator: Number of population patients discharged Baseline: New patients over DY3 Goal: 225 new patients in the program	

094108002.2.3	2.12.1	2.12.1, A,B,C,D,E, F, G	DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS	
Mother Frances Hospital				**094108002**
Related Category 3 Outcome Measure(s):	**094108002.3.6**	**IT-3.1**	**All cause – 30 day readmission rate- NQF 1789**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	population receiving care according to standard protocol b. Denominator: Number of population patients discharged Baseline: New process, 0 patients in program Goal: 200 patients in the program Data Source: Hospital administrative data and the patient medical record **Milestone 7 Estimated Incentive Payment $95,044**		Data Source: Hospital administrative data and the patient medical record **Milestone 10 Estimated Incentive Payment $129,481**	
Year 2 Estimated Milestone Bundle Amount: **$340,656**	Year 3 Estimated Milestone Bundle Amount: **$380,173**		Year 4 Estimated Milestone Bundle Amount: **$388,442**	Year 5 Estimated Milestone Bundle Amount: **$323,187**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: **$1,432,458**				

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 094127002.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Carthage 094127002

Project Abstract

Provider: East Texas Medical Center Carthage (ETMC) is a 49-bed, full-service hospital dedicated to serving the Panola County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Panola County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 242,000.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 1,033 new primary care clinic patients each year with a Medicaid and indigent share of at least 30%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 1,550 patients. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 14,462 emergency room visits in 2012—including 10,331 non-urgent visits (71.4%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Carthage		
Level of Care	**ED Visits**	**Percent**
1 Resuscitation	29	0.2%
2 Emergent	189	1.3%
3 Urgent	3,913	27.1%
4 Semi Urgent	7,360	50.9%
5 Non Urgent	2,971	20.5%
Grand Total	**14,462**	**100.0%**
Percent Non-Urgent	10,331	71.4%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (094127002.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (094127002.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (094127002.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The

relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $816,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $378,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		10,331
% Clinic Appropriate		15%
Clinic Appropriate Patients		1,550
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**1,046,618**
Clinic Payment @ 78% savings	$	230,256
Total Estimated Savings	**$**	**816,362**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

094127002.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Carthage			*094127002*
Related Category 3 Outcome Measure(s):	***094127002.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $297,465	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [515] out of a baseline of 10,331 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $324,518	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [1,033] out of a baseline of 10,331 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $325,462	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 15% [1,550] out of a baseline of 10,331 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $268,860
Year 2 Estimated Total DSRIP: $297,465	Year 3 Estimated Total DSRIP: $324,518	Year 4 Estimated Total DSRIP: $325,462	Year 5 Estimated Total DSRIP: $268,860
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,216,305***			

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 094190802.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Fairfield 094190802

Project Abstract

Provider: East Texas Medical Center Fairfield (ETMC) is a 48-bed, full-service hospital dedicated to serving the Freestone County area with advanced diagnostics, medical and surgical care, and outpatient services. ETMC's primary service area is Freestone County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 258,782.

Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.

Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.

Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 445 new primary care clinic patients each year with a Medicaid and indigent share of at least 25%.

Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 667 patients. Patients will benefit from access to a primary care provider and follow-up care.

Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 15% of non-urgent emergency room patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-

urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 8,974 emergency room visits in 2012—including 4,445 non-urgent visits (49.5%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Fairfield		
Level of Care	**ED Visits**	**Percent**
Unknown	76	0.8%
1 Resuscitation	32	0.4%
2 Emergent	851	9.5%
3 Urgent	3,570	39.8%
4 Semi Urgent	3,513	39.1%
5 Non Urgent	932	10.4%
Grand Total	**8,974**	**100.0%**
Percent Non-Urgent	4,445	49.5%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is

to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (094190802.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (094190802.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (094190802.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $351,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $236,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		4,445
% Clinic Appropriate		15%
Clinic Appropriate Patients		667
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**450,316**
Clinic Payment @ 78% savings	$	99,070
Total Estimated Savings	**$**	**351,247**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

094190802.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Fairfield			*094190802*
Related Category 3 Outcome Measure(s):	***094190802.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $186,290	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [223] out of a baseline of 4,445 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $203,232	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [445] out of a baseline of 4,445 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $203,823	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 15% [667] out of a baseline of 4,445 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $168,376
Year 2 Estimated Total DSRIP: $186,290	Year 3 Estimated Total DSRIP: $203,232	Year 4 Estimated Total DSRIP: $203,823	Year 5 Estimated Total DSRIP: $168,376
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$761,721***			

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 121817401.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Trinity 121817401

Project Abstract

Provider: East Texas Medical Center Trinity (ETMC) is a 30-bed, full-service hospital dedicated to serving the Trinity County area with advanced diagnostics, medical and surgical care, outpatient services, and a Level IV trauma center. ETMC's primary service area is Trinity County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 94,915.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 672 new primary care clinic patients each year with a Medicaid and indigent share of at least 35%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 1,009 patients. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 15% of non-urgent emergency room patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent

patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 7,692 emergency room visits in 2012—including 6,727 non-urgent visits (87.5%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Trinity		
Level of Care	**ED Visits**	**Percent**
Unknown	18	0.0%
1 Resuscitation	17	0.0%
2 Emergent	81	0.2%
3 Urgent	849	1.9%
4 Semi Urgent	3,228	7.3%
5 Non Urgent	3,499	8.0%
Grand Total	**7,692**	**17.5%**
Percent Non-Urgent	6,727	87.5%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is

to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (121817401.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (121817401.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (121817401.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $531,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $340,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		6,727
% Clinic Appropriate		15%
Clinic Appropriate Patients		1,009
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**681,502**
Clinic Payment @ 78% savings	$	149,931
Total Estimated Savings	**$**	**531,572**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

121817401.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
	ETMC Trinity		*121817401*
Related Category 3 Outcome Measure(s):	***121817401.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $268,139	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [336] over baseline of 6,727 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $292,525	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [672] over baseline of 6,727 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $293,375	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 15% [1,009] over baseline of 6,727 non-urgent **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $242,353
Year 2 Estimated Total DSRIP: $268,139	Year 3 Estimated Total DSRIP: $292,525	Year 4 Estimated Total DSRIP: $293,375	Year 5 Estimated Total DSRIP: $242,353
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,096,392***			

Project Option: 2.15.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. (Lakes Regional Care Integration Project)
Unique Project ID Number: 121988304.2.1
Performing Provider Name/TPI: Lakes Regional MHMR Center 121988304

Project Abstract

Provider Description: Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays. Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year Over 95% of our consumers are either Medicaid eligible or indigent.

Intervention(s): The project will implement integrated Physical services into three existing rural Behavioral Health Centers allowing individuals with need for primary care to choose LRMHMRC as a medical home to improve physical and behavioral health outcomes.

Need for the project: There is currently a lack of health provider capacity that will serve the Medicaid and indigent population in the surrounding rural communities where the behavioral health clinics are located. The project will provide currently served individuals with serious mental illness and without a PCP access to integrated physical health at the place they receive behavioral health service for improved outcome (current enrollment approximately 1400). It will provide fully integrated services for those who choose it and a culture of case management that will meet the level 2 and 3 standards for collaborative care for those who choose another medical home.

Target population: The target population is individuals being served in the Behavioral Health Centers needing access to primary care services with an indigent population priority. Approximately 95% of our patients are either Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: Primary care integrated with behavioral health care and co-located is expected to produce dramatically better recovery for individuals served in the clinics greater satisfaction with their access to integrated care, improvements in quality of life and reduced use of emergent and crisis oriented public services. The project estimates inclusion ~~in excess of 400~~ a minimum of 500 patients choosing these services as their medical home by the end of the Waiver.

Category 3 outcomes: IT-6.1 Patient Satisfaction - With the regular functional tracking of progress through assessments performed in the behavioral health centers, the outcome instrument chosen for the project was a validated standardized patient satisfaction survey. The projected improvement percentage is an aggregate 15% above baseline for those participating maintained through ~~DY 4 and~~ DY-5.

Project Narrative

Project Description: Primary care in rural areas is sparse and not available to many patients with Serious Mental Illness (SMI) of Community Centers due to multiple barriers of individual limitations as well as external barriers of poverty, distance and access. Delivery Solution: Lakes Regional Care Integration Project. Lakes Regional Mental Health Mental Retardation Center (LRMHMRC) will survey the client population in each of three rural behavioral health clinics to establish Primary Care access, barriers, needs and alternatives used. LRMHMRC will survey area resources for Primary Care existing and planned Waiver projects by other entities to determine Primary Care availability and gaps for the SMI population. LRMHMRC will create co-located primary care for integrated care and medical records for individuals receiving services for SMI through the creation of a mobile medical clinic (MMC) service between rural behavioral health centers. The project will provide a medical home of basic primary care services and health screening to the SMI clinic population not connected to other community primary care providers. Educational awareness and referral training of staff will be created to ensure success in integration. Project population health needs surveying will occur in the initial year with baseline data collection and inform the development of program plans including staffing, equipment, training, parameters, protocols, records, vehicle base preparation, supplies, and clinic scheduling. As the project is operational in DY3, tracking of impact through health data records along with other evaluative instruments and PDSA cycles will inform program improvements as the percent of population served increases. Agency Policies and Procedures will be altered to include integration of care into the fabric of daily activities and the protocols into treatment team meetings, treatment and recovery planning, and therapeutic decisions. As in the intent of the Waiver and the RHP 1 goals, LRMHMRC seeks to reduce regional health care costs and misuse of resources by enhancing access to integrated health care at the appropriate level in the correct place.

Project Goals: The goal for voluntary participants is to have a Primary Care Provider (PCP) conveniently available at the facility at which they receive their mental health care with integrated health records and open planning and consulting for the best possible personal outcome: measureable increases in physical and mental health as well as improvements in the quality of life and satisfaction with the services they receive. This would include necessary and regular health screening, physical examinations and referral for conditions outside the parameters of the program and requiring specialist attention. The goals for LRMHMRC as the Participating Provider is a transition in the agency toward integrated care, whole person integrated thinking, and greater recognition of the impact and benefits of physical health maintenance services provided cooperatively; first through education and then through experience with client sharing. More specifically, LRMHMRC Regional seeks to:

1. Expand capacity of primary care to better accommodate the needs of the SMI population so that the right care at the right time in the right setting is delivered.
2. Co-locate and integrate behavioral health and primary care so that care can be better coordinated and the patient can be treated as a whole person, potentially leading to better outcomes and experience of care.
3. Link patients with serious mental illnesses to a medical home or another care management program where such is individually available and preferred.

4. Educate and/or train behavioral health clinicians in primary care awareness and referral to care.
5. Increase the number of behavioral health patients with a primary care need, who have access to Primary Care Providers
6. Develop and implement standardized primary care referral and work-up guidelines.
7. Decrease unnecessary emergency department usage by individuals enrolled in the behavioral health system
8. Finally, LRMHMRC desires that the health and progression of the individuals served move more rapidly in recovery.

Describe any challenges or issues: A recent report, Physical Health Conditions Among Adults with Mental Illness, revealed that this population is more likely to have chronic high blood pressure asthma or stroke in the past year than the general population and was 47.6% versus 28.7% more likely to have had an emergency department visit and to be hospitalized (18.1% vs. 10.1%) (SAMHSA, 2012). In areas of Region 1 served by the clinics of LRMHMRC experience would support these observations. Region 1 Community Needs Assessment (CAN) shows that these conditions were the basis for over 50,000 hospitalizations in the 5 year period beginning 2005. LRMHMRC serves the SMI population in 8 of the 28 counties. Many of the individuals served do not have a PCP attending their physical health with which the agency could collaborate as the effects of psychotropic medicine enhanced weight gain takes a toll. It is common for psychiatric recommendations to seek physician services for high blood pressure or other risk indicators go unheeded due to impediments. These individuals need basic physical health services and personal health care information integrated with their mental health services for better outcomes.

The 5-year expected impact: Individuals served in this program will experience increased satisfaction with their integrated health care, decreased emergency room visits and hospitalizations, and consistently report improved quality of life. Further LRMHMRC has the goal of seeing reductions in risk and poor health markers that suggest an impact of the program across the population served and reduce the likelihood of potentially preventable hospitalizations or need for higher levels of care from occurring consistent with regional and transformation waiver goals. This reduction in cost as well as the integration of care services in this project meets the aims of the waiver and Center for Medicare and Medicaid Services (CMS) as well.

Starting Point/Baseline: Formal relationships of cooperation do not exist between physical health providers and behavioral health providers and shared clientele in the SMI population are not known but are estimated at 800 ~~400~~ of the 1,400 population of the three (3) Lakes Regional MH clinics in this area. Many individuals receiving behavioral health services report or are recognized as having physical health difficulties during psychiatric and nurse appointments and are instructed to follow-up with a health care provider at the level appropriate to the concern. Knowing that resources are few with waiting lists for indigent care in federally funded clinics running into months, little hope or criticism is due the lack of follow through. Behavioral health records reveal significant numbers in the population that have been diagnosed with

concurrent physical ailments that would require on-going tracking or treatment if integrated primary care was available. Applying the Four Quadrant Model the majority would be in either the first or fourth quadrant. Physical health and integration awareness training will be provided for all staff. Encounters with area health care providers thus far have yielded little information on alternatives to providing the necessary Primary Care services. During DY2 of the Waiver, the pertinent baseline data will be developed through gap analysis of the availability of existing and proposed physical health resources to the SMI population as well as the population profile of health needs. LRMHMRC will be developing the project infrastructure and establishing the benefits to the population and secondary impact to the community health services such as monitoring emergency department usage over the course of the Waiver.

Rationale: It is a well-established fact that individuals in the SMI population have multiple health needs and lack access to a primary care physician due to financial status and interfering symptoms of mental illness. Positive behavioral healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specific need for care has been identified. Stable physical health and on-going treatment for chronic physical conditions are essential to the success of behavior health treatment and psychiatric medications. Access to Primary Care integrated with Behavioral Health Care is important because newer medications used to treat mental illnesses put patients at increased risks for diabetes and other metabolic problems. By increasing access to behavioral, social and medical services, there is potential to reduce the risk of repeated hospitalizations. Co-location of services has shown great cost benefits, patient satisfaction and quality of care.

Describe the reason(s) for selecting these project components: Under the Category 2.15.1 Project Option the Required Core Components are addressed as follows:

a.) Identify sites for integrated care projects – A base for the mobile medical clinic will be established near the LRMHMRC clinic in Paris, TX. From that site the MMC will make a weekly route to prepared linkage space among the clinics in towns of Paris, Sulphur Springs and Mt. Pleasant in Texas to provide primary care services. The clinic populations are in excess of 1.400 individuals allowing them to appoint primary care in concert with their behavioral health care or at least in an accessible and familiar place. Consistent availability of primary care staff will be maintained through the agency's telemedicine network. All center staff will have training during the initiation of the project to integrated services and what it can do for the outcome of services to assist them in transitioning to the consciousness and role changes to come.

b.) Co-scheduling and information sharing – The LRMHMRC EMR which includes modules for scheduling all services will be used to include the physical health records component.

c.) Protocols and processes for communication, data-sharing, and referral – In DY2 and DY3 significant planning activities will be put into the creation of the project parameters and protocols toward level 5 integration.

d.) Number of specialty providers – LRMHMRC has MH rehabilitation, case management, nurse, therapists and psychiatric providers at each clinic and the MMC will provide the physical health component. Relations will be developed with other referral and hospital

services in the communities. Consultation with other Specialists as needed will be available the through the agency telehealth network.

e.) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:

- **i. Regular consultative meetings between physical health and behavioral health practitioners; - DY3 will see the bulk of preparatory training occur with the MMC staff joining LRMHMRC and establishing the routing and consultation schedules.**
- **ii. Case conferences – A part of the curriculum for staff training will cover integrated case conferencing presentations in a formal and/or ad hoc basis.**
- **iii. Shared treatment plans co-developed – The development of the project plan in DY2 will cover protocols for integrated treatment planning.**

f.) Data reporting, communication and collection will rely heavily on the Electronic Medical Record (EMR) in place with any modules added as needed to facilitate complete integration.

g.) Legal agreements that may be needed will be explored by center contracts personnel, legal counsel and project consultants.

h.) Utilities and building services for all of LRMHMRC facilities are covered by the business department which will assume physical preparations for the base, vehicle and clinic connections beginning in DY2.

i.) Develop and implement data collection and reporting mechanisms – In the preparations of DY2, standards to track utilization of MH and SA services will be expanded to integrated services as well. The health care outcomes of individuals treated in these integrated service settings will become a part of the overall continuous quality improvement (CQI) and utilization monitoring processes.

j.) Quality improvement for the project will include plan, do, study, act cycles to ensure continuous attention to improvement.

Reasons for selecting the milestones and metrics: Comprehensive collaborative and structured mental health services provided to high utilizers of mental health services resulted in a 65% reduction in community hospital days (Anderson, N., 2002). Patients with serious mental illness receiving care in Veterans Affairs mental health programs with co-located general medical clinics were more likely to receive adequate medical care than patients in programs without co-located clinics based on a nationally representative sample (Kilbourne, A., 2011). DY2 will have multiple activities around P-1 **"**Conduct needs assessment…" and P-3 "Develop and implement a set of standards to be used for integrated services…" to inform the project in developmental stages. DY3 milestones P-7 will establish continuous improvement mechanism and P-5 will reflect the site development for the opening of services. Milestone 5 [I-8]: Integrated Services with Metric I-8.1 was chosen to target penetration of services into the population for DY4 and DY5 (Milestone 7). Impact on the health and function was chosen for DY 4 and DY 5 also through the I-11 milestone (Milestones 6 & 8) and a related array of health metrics.

Unique community need(s) the project addresses:

Community Need Identification Number:

(CN.1) Insufficient access to primary and specialty health care services with

(CN.3) High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
(CN.4) High costs due to potentially preventable hospital admissions/readmissions
(CN.5) Inappropriate emergency department utilization
(CN.6) the need for Efficiency in and effectiveness of health care delivery.

Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project will require the development of an option for primary care that is outside of the conventions of the present circumstances. Introduction of a medical home wholly integrated into LRMHMRC services will provide integrated care in these rural communities to an underserved population unlikely to receive comparable health care from another resource for the foreseeable future. The project is anticipated to result in greater use of primary care, health recommendations and improved health and behavioral health outcomes.

Related Category 3 Outcome Measure(s): Outcome Domain (OD) – 6 Patient Satisfaction was chosen as the OD for the project with IT-~~6.1~~ 6.2 as the Improvement Targets. LRMHMRC will employ the validated instrument Mental Health Statistics Improvement Program Consumer Survey (MHSIP). The MHSIP (developed by CMHS and SAMHSA for community MH block grant requirements) provides a standard instrument and protocol for data collection and processing (Green, R, & Newman, F., 1996) and is seen as an outpatient mental health equivalent to the Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS). Patient satisfaction is a fundamental way to ensure that LRMHMRC is meeting the needs of the SMI population in their integrated care. It will inform the Plan, Do, Act, Study (PDSA) process for continued improvement. The initial preparations for the project with health data collection on service participants to profile baseline function will be used to determine other outcome targets related to the health and risk statistics of individual participants and the population in the clinics.

Relationship to other Projects: The project ties to 121988304. 1.1 (1.12.2) - Expand the number of community based settings where behavioral health services may be delivered in underserved areas (Lakes Regional Depression/Trauma Clinics), also proposed in this RHP 1 Plan.

Relationship to Other Performing Providers' Projects in the RHP: A few other providers are proposing similar projects hopefully reducing hospital emergency department use for behavioral crisis but are doing so in other counties within the region. The target group for these other projects does not overlap with the area served by LRMHMRC. However, LRMHMRC will seek to share experiences in approach and lessons learned within the region toward discovering best practices.

Plan for Learning Collaborative: The region has intentions of developing a learning collaborative stating, "As the region's providers implement improvements, it is important that they learn from each other's successes and challenges, as well as identify best practices that can be widely replicated." LRMHMRC is aligned with this sentiment and supportive of these regional efforts. To this end, Region 1 will develop learning collaboratives that focus on: Sharing

knowledge, experience and expertise; improving patient and caregiver experience; implementing evidence-based guidelines; using data-driven analyses to drive performance improvement; and Testing, such as through Plan-Do-Study-Act (PDSA) cycles.

Project Valuation: Access to Primary Care integrated with Behavioral Health Care is important because newer medications used to treat mental illnesses put patients at increased risks for diabetes and other metabolic problems. By increasing access to behavioral, social and medical services, there is potential to reduce the risk of repeated hospitalizations. Co-location of services has shown the great cost benefits, patient satisfaction and quality of care. The scope of this project could impact a minimum potential of 500 ~~400~~ patients in a largely rural medically underserved geographic area. This project was valued based upon integrated care valuation research completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: *Valuing the Program to Provide Integrated Physical and Behavioral Health Care for Individuals with High-Acuity Behavioral Health Needs Center for Health Care Services (CHCS) – Bexar County Region 6 – University Health System.* This valuation used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value per QALY gained due to the intervention multiplied by number of participants. A complete write-up of project will be available at performing provider site.
Total Five Year Valuation: $3,438,954

References:

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (April 5, 2012). *The NSDUH Report: Physical Health Conditions among Adults with Mental Illnesses*. Rockville, MD.

Nancy Anderson, "Medical Cost Offsets Associated with Mental Health Care" A Brief Review, ***Washington State Dept. of Social and Health Services****, December, 2002.*

Kilbourne, A et al., "Quality of General Medical Care Among Patients With Serious Mental Illness: Does Co-Location Matter?", ***Psychiatric Services****, Vol 62, No. 8, 2011*

Green, R. S. & Newman, F. L., The Final Report of the Mental Health Statistics Improvement Program (MHSIP), Task Force on a Consumer-Oriented Mental Health Report Card, SAMHSA, CMHS, April, 1996.

121988304. 2.1	**2.15.1**	2.15.1a-j	Design, implement and evaluate projects that provide integrated primary and behavioral health care services: (Lakes Regional Care Integration Project)	
Lakes Regional MHMR Center				121988304
Related Category 3 Outcome Measure(s): OD- 6	**121988304.3.2**	**IT-~~6.1~~ 6.2**	Patient Satisfaction	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct 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-1.1.Metric 1 [**Numbers of patients in various areas who might benefit from integrated services. Demographics, location, & diagnoses – P-1.1]: **Goals/Baseline**: Collect data to establish baselines for clinic population primary care access, emergency department usage, time since last physical, physical health needs, and community health resources used and available. **Data Source:** Project electronic data files from survey of client medical records, client responses to direct survey reporting and survey of area physical health resources and baseline data. Milestone 1 Estimated Incentive Payment: **$635,681**	**Milestone 3** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services. **Metric 3** [Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles – P-7.1]: **Goals**: Conduct PDSA cycles to improve data collection and intervention activities. Train existing direct care staff to improve awareness of physical needs, referral guidelines and linkage to resources. Take possession of the Mobile Health vehicle and execute preparation, equipping and supplying elements of the project plan. Hire & train program staff positions. **Data Sources:** PDSA reports, project reports, HR & training records, Project operations and protocol plan. Milestone 3 Estimated Incentive Payment: **$ 363,054** **Milestone 4 [P-5]:** Develop integrated sites reflected in the number of locations and providers	**Milestone** 5 [I-8]: Integrated Services **Metric 5** [200 ~~30%~~ of selected Individuals receiving both physical and behavioral health care at the established locations - I-8.1]: **Goals:** Expand initial pool of SMI clients served in integrated care model ~~to <30% of population~~ in each clinic. ~~Provide prescription services at Depression/Trauma clinics for <30% of identified individuals meeting criteria in protocol plans to move between clinics.~~ **Data Source:** Client EMR, program records, PDSA reports Milestone 5 Estimated Incentive Payment: **$376,440** **Milestone 6 [PI-11]:** Health Metrics Metric 6 [7.5% ~~10%~~ Increase in Positive Results of Standardized Health Metrics, which may include : • Objective health indicators such as Body Mass Index, glycated hemoglobin (A1c), blood pressure, and other specific blood assays, etc. • Behavioral health instruments such	**Milestone 7 [I**-8]: Integrated Services **Metric 7** [~~60%~~ 500 of eligible Individuals receiving both physical and behavioral health care at the established locations - I-8.1]: **Goals:** Expand initial pool of SMI clients served in integrated care model ~~to <30% of population~~ in each clinic. ~~Provide prescription services at Depression/Trauma clinics for <30% of identified individuals meeting criteria in protocol plans to move between clinics.~~ **Data Source:** Client EMR, program records, PDSA reports Milestone 7 Estimated Incentive Payment: **$344,301** Milestone 8 [PI-11]: Health Metrics Metric 8 [10% Increase in Positive Results of Standardized Health Metrics, which may include : • Objective health indicators such as Body Mass Index, glycated hemoglobin (A1c), blood pressure, and other specific blood assays, etc.

121988304. 2.1	**2.15.1**	2.15.1a-j	Design, implement and evaluate projects that provide integrated primary and behavioral health care services: (Lakes Regional Care Integration Project)	
Lakes Regional MHMR Center				121988304
Related Category 3 Outcome Measure(s): OD- 6	**121988304.3.2**	**IT-~~6.1~~ 6.2**	Patient Satisfaction	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. **P-3.1.Metric 2 [**Number and types of referrals that are made between providers at the location – P-3.1]: **Goals:** Set parameters for Mobile Medical Clinic referrals - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Surveying data, research mobile health programming, consultation input, program files Milestone 2 Estimated Incentive Payment: **$635,681**	participating in the integration project. **P-5.2. Metric 4** [Number of primary care providers newly located in behavioral health settings.]: **Goals:** One primary care providers serving in three clinic locations. **Data Source:** Clinic schedules, EMR, program files Milestone 4 Estimated Incentive Payment: **$363,055**		as the Quality of Life (QOL) Questionnaire, the Adult Needs and Strengths Assessment (ANSA) – I-11.1]: **Goals:** ~~TBD~~ 7.5% from DY2 project plan and baseline participant assessment records **Data Source**: EMR, protocol standards and project records. Milestone 6 Estimated Incentive Payment: **$376,440**	• Behavioral health instruments such as the Quality of Life (QOL) Questionnaire, the Adult Needs and Strengths Assessment (ANSA) – I-11.1]: **Goals:** ~~TBD~~ 10% from DY2 project plan and baseline participant assessment records **Data Source**: EMR, protocol standards and project records. Milestone 8 Estimated Incentive Payment: **$344,301**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): **$1,271,362**	Year 3 Estimated Milestone Bundle Amount: $ **$ 726,109**		Year 4 Estimated Milestone Bundle Amount: **$752,880**	Year 5 Estimated Milestone Bundle Amount: **$688,603**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* **$3,438,954**				

Project Option: 2.13.1 Design, implement, and evaluate research – supported and evidence-based interventions tailored towards individuals in the target population. Required core components: a) through e). (Lakes Regional MHMR Center In SHAPE).
Unique RHP Project Identification Number: 121988304.2.2
Performing Provider Name/TPI: Lakes Regional MHMR Center 121988304

Project Abstract

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

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

Intervention(s): This project will implement a research supported physical health and nutrition awareness and improvement program for individuals with medication stabilized schizophrenia related disorders. The program In SHAPE has been demonstrated to provide substantial increases in health and quality of life in the population through individualized health action plans under the guidance of a Health Mentor.

Need for the project: The effects of antipsychotic medications is a devastating weight gain that results in major cardiovascular and endocrine system problems in a majority of individuals treated. These life altering and in many patients life threatening side effects compound the difficulties of those in treatment in self-esteem and social inclusion as well as other life arenas. It is incumbent upon the systems that treat with these medications to do what is possible to manage these effects.

Target population: The target population is clients needing specialty services for improving personal physical health and nutrition through semi-weekly guidance consults. The project will graduate 89 participants of 108 enrolled (18 each six month period for DY3, 4 & 5) who are in services at the clinic and stable enough for participation over the six month duration of the program. Approximately 95% of our patients are either Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: The project seeks to provide individualized health mentoring for approximately 6 months for ~~80 to 100~~ 89 individuals through the Waiver period with resulting improvements in monitored health status indicators, community social engagement and mental functioning assessments.

Category 3 outcomes: IT-6.1 Patient Satisfaction. The projected outcomes relate to an improvement in standardized patient satisfaction surveys over baseline studies. Patient satisfaction will be a strong component in the maintenance of physical and life style gains made in the program. The projected improvement percentage is 10% mean for growing aggregate treatment participant for the waiver..

Project Narrative

Project Description: Lakes Regional MHMR Center (LRMHMRC) proposes to affect the negative trend in Hunt County that the seriously mentally ill (SMI) population, especially those in rural and poverty

stricken areas, have dramatically shortened life expectancy by implementing the wellness program **Individualized Self Health Action Plan for Empowerment (In SHAPE)** researched and promoted by the "Prevention Research Center at Dartmouth" which is part of The Dartmouth Institute. The heart of the program is an individualized physical health care program for people with SMI developed with a specially trained Health Mentor for one-on-one education, planning, coaching, training and measuring progress toward goals with reflection on the benefits and appreciation of accomplishment. Health Mentor is a designation developed by In SHAPE that requires additional training to that required to be a "Certified Personal Trainer" by the Aerobics and Fitness Association of America. One Health Mentor can work with up to 16 to 20 individuals at a time for the first 6 months in program; therefore, a six month commitment by participants to the program is desired. Lakes will structure a Health Mentor to work with 18 individuals each 6 month period beginning in DY3 to expose 108 participants over the course of the waiver and graduate 89. The Health Mentor meets with individuals 1 or 2 times per week, but the program is designed to be highly individualized with a focus on designing exercise and nutrition plans that are sustainable in a more health directed lifestyle. It is obvious that community partners are critical in providing these services in community sites like the YMCA.

Describe the project goals: This project will expand the capacity of behavioral health services to better meet the needs of the patient population and community so that care can be better coordinated, and the participant can be treated as a whole person, potentially leading to better outcomes and experience of care. The program is aimed directly at improving physical health, personal health knowledge and quality of life of participants (minimum 89) thereby reducing the risk of preventable diseases, lowering health care costs and enhancing the life expectancy of individuals with severe mental illness (SMI).

Describe any challenges or issues: It has been well established that the SMI population especially those in rural and poverty stricken areas have dramatically shortened life expectancy fraught with physical health difficulties from medication side effects such a morbid obesity, diabetes, and heart disease as well as high instances of preventable diseases from smoking, diet and other life style choices. They have been called the most disadvantaged group in the U.S. in terms of life expectancy 15 to 30 years less than the rest of the population (Lunardini, R., 2011).

The 5 Year Expected Outcome: The Five (5) year expected outcome will be that 89 graduating participants' physical health awareness, health status indicators and physical functioning will show measureable improvements leading to corresponding cognitive improvements. Participants will also show consistent compliance with their medication regimen with related improvements in mental functioning as tracked through the waiver period. Participants learn through close mentoring, instruction and planning how they individually can adopt healthier choices and behaviors, gain control over weight problems and increased energy. With this comes a sense of mastery and self-direction rare to this population. Patient satisfaction and medication compliance will increase and health status indicators will improve. In a nine month pilot study, significant level outcomes were increases in vigorous activity and walking, readiness to reduce caloric intake, reduction in waist circumference, satisfaction with fitness, mental health functioning improved, and severity of negative symptoms decreased (Van Citters, AD, et. Al., 2009). Decreases in medications may occur as physiological processing becomes more efficient and increases in social activity, personal efficacy and purpose can lead to increased employment and quality of life.

Relationship to Regional Goals: In keeping with regional goals, the project is to avert outcomes such as potentially avoidable inpatient admission and readmission in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community as articulated the RHP protocol page 300.

Starting Point/Baseline: This will be a new addition to the LRMHMRC array of services of a tested and proven program design (Van Citters, AD, et. Al., 2009). The program will be new to the area and the population to be served as well. Consultation and guidelines in keeping with the replication of the program in other mental health centers will be followed (Crum, 2009). As a result, the community resources in each of the planned areas will need to be surveyed and assessed for possible partnership and facility appropriateness. Health Mentors will need to be identified from available certified personal trainers (hired or contracted) and trained further. Their initial pool of clients to start the program will need to be identified through a systematic surveying of the client population to establish baseline data and selection criteria.

Rationale: The project option is 2.13.1: Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. People with SMI often have multiple concomitant conditions such as substance abuse, traumatic injuries, cognitive challenges and lack of daily living skills or natural supports. To advance from mere stabilization, this population requires individualized services which serve the whole persons need for physical, mental and community social improvements. In SHAPE is just such a program that is research supported and has proven effective in achieving these gains for this population.

Reasons for selecting these project components: The project will address all components of 2.13.1 including:

a). Assess size, characteristics and needs of target population- this is to be determined through gap analysis/baseline surveying in DY2.

b). Review literature- DY2 will also be a period to review the relevant literature and engage consultant services in project development.

c). Develop project evaluation plan- a plan, do, study, act (PDSA) approach will be instituted for continuous evaluation and quality improvement; the Adult Needs and Skills Assessment (ANSA) scores taken quarterly along with the SF-36 responses and in program functional testing will be used in the evaluation process.

d). Design models- In SHAPE is a research supported program and consultation will advise the adaptations to the current context.

e). Assess the impact of interventions- as above, continuing evaluation of client improvement on several dimensions with standardized instruments will inform personal impact and across participants indicate programmatic impact and PDSA cycles.

Reasons for selecting the Milestones and Metrics: DY2 and DY3 Process Milestones enable the project start-up. Milestones 1 and 2 will prepare the base of the program by [P-1] conducting needs assessment and hire and train personnel [P-X]. Enrollment to serve ~~16 to 20~~ individuals in blocks of 18 each six months in DY3, 4 & 5 with SMI [P-3] after selection from DY2 data and PDSA cycles [P-4] will allow continuous evaluation moving into the improvement target years DY4 and DY5. Milestones 5 and 7 [I-3] will track improvement from the electronic medical record (EMR) the compliance with prescribed anti-

psychotic medication; Milestones 6 and 8 [I-5] functional status will inform on improvements in standard measures using the ANSA and physical health measurements (ie. BMI, HBP, Ha1c) quarterly.

Unique community needs the project addresses:

- CN.3 High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
- CN.4 High costs due to potentially preventable hospitalizations.

Describe how the project represents and new initiative or significantly enhances an existing deliver system reform initiative: LRMHMRC and Texas community centers generally have not entered the realm of physical activity services to SMI clients. This new venture from a proven model provides great potential for improvement in the condition of individuals with schizophrenia which is likely to provide a positive influence on family, peers and staff members as well.

Related Category 3 Outcome Measure(s): OD – 6: Patient Satisfaction: IT-6.1: Percent improvement over baseline of patient satisfaction scores. The devastating side effect of newer anti-psychotics causing metabolic syndrome is one of the most difficult thing for most people to fight. It requires strong support for a participant's sense of accomplishment and progress to stay with the effort involved in making this change in lifestyle. Satisfaction with the progress, program, clinician and organization are critical to the tenacity required in accomplishing both the participant's goal and the goals of the project. Lakes Regional's goal is to maintain ~~an average 10%~~ improvement over individual baseline of per individual satisfaction scores with the growing aggregate of program participants' overall health status/functional status for ~~DY 4 and~~ DY-5.

Relationship to other Projects: The project focus on physical health difficulties from medication side effects such a morbid obesity, diabetes, and heart disease as well as high instances of preventable diseases from smoking, diet and other life style choices within the SMI population ties to other RHP projects including:

- 121988304.2.1 – Lakes Regional Integrated Care Project
- 121988304.1.1 - Depression Trauma Counseling Center

Related Category 4 Population focused improvements: N/A

Relationship to Other Performing Providers' Projects in the RHP: A few other providers are proposing similar projects hopefully reducing hospital emergency department use for behavioral crisis but are doing so in other counties within the region. The target group for these other projects does not overlap with the area served by LRMHMRC. However, LRMHMRC will seek to share experiences in approach and lessons learned within the region toward discovering best practices.

Plan for Learning Collaborative: The region has intentions of developing a learning collaborative stating, "As the region's providers implement improvements, it is important that they learn from each other's successes and challenges, as well as identify best practices that can be widely replicated." LRMHMRC is aligned with this sentiment and supportive of these efforts. To this end, Region 1 will develop learning collaboratives that focus on: Sharing knowledge, experience and expertise; improving patient and caregiver experience; implementing evidence-based guidelines; using data-driven analyses to drive performance improvement; and Testing, such as through Plan-Do-Study-Act (PDSA) cycles.

Project Valuation: This project was initially valued using scoring criteria guidance with a 1 to 5 scoring range and the following criteria: Meets Waiver Goals; Addresses Community Needs; Project Scope; Project Investment; Value Weight of the Project.

In addition, this project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: The studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). The complete descriptions of the project research studies are available at the performing provider site. Additional cost effectiveness savings can also be assumed through avoidance of higher cost crisis emergency based services and transportation costs as a result of increased specialty care access due to this project.

Total Five Year Valuation: $ 641,676

References

Luarndini, R., In SHAPE: Local Pilot Becomes National Model, Dartmouth Medicine, Winter 2011.

Van Citters, A. D., Pratt, S. I., Williams, G., Miller, P. T., Xie, H., and Bartels, S. J., A Pilot Evaluation of the In SHAPE Individualized Health Promotion Intervention for Adults with Mental Illness. *Community Mental Health Journal*, 46(6): 540-552, 2010.

Crum, R., Business Planning to Replicate In SHAPE, a Program Promoting Health for People with Mental Illness, Robert Woods Johnson Foundation Grant Results Report, June, 2009.

Barr, B. M., Adults with Severe Mental Illness Get In SHAPE, Robert Woods Johnson Foundation Grant Results Report, Grant Id: 51433, January 14, 2011.

121988304.2.2	2.13	**2.13.1** a-e	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting **(IN SHAPE)**
Lakes Regional MHMR Center			121988304
Related Category 3 Outcome Measure(s): OD-6	121988304.3.3	IT – 6.1	Patient Satisfaction 6.1

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1. Milestone: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources create inclusion criteria and program protocol. **P-1.1. Metric**: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ER utilization. **Baseline/Goal:** Inform planning and selection of needs of participants and stakeholders **Data Source**: Project documentation; EMR sample	**Milestone 3** [P-3]: Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities.) **Metric 3 [P-3.1]** Number of targeted individuals enrolled / served in the project is 16 to 20. **Baseline/Goal:** 36 individuals enrolled and served. **Data Source:** Project	**Milestone 5 [I-3]:** Adherence to Antipsychotics for Individuals with Schizophrenia. **Metric 5[I-3.1]:** The percentage of individuals with schizophrenia receiving the specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the measurement period (12 consecutive months). a. Numerator: The ~~TBD~~ ~~percentage~~ 30% of individuals with schizophrenia who filled at least two prescriptions for an antipsychotic and had a PDC for antipsychotic medication that is greater than or equal to 0.8.	**Milestone 7 [I-3]:** Adherence to Antipsychotics for Individuals with Schizophrenia. **Metric 7 [I-3.1]:** The percentage of individuals with schizophrenia receiving the specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the measurement period (12 consecutive months). a. Numerator: The ~~TBD~~ ~~percentage~~ 40% of individuals with schizophrenia who filled at least two prescriptions for an antipsychotic and had a PDC for antipsychotic medication that is greater than or equal to 0.8.

121988304.2.2	2.13	**2.13.1** a-e	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting **(IN SHAPE)**
Lakes Regional MHMR Center			121988304
Related Category 3 Outcome Measure(s): OD-6	121988304.3.3	IT – 6.1	Patient Satisfaction 6.1

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
of potential participants ~~Inpatient, discharge and ER and HMO records; State psychiatric facility records~~; survey of stakeholders ~~(inpatient providers, mental health)~~ **Milestone 1 Estimated Incentive Payment: $73,840** **Milestone 2 [P-X]**: Hire and train certified personal trainer to become health mentor. **Metric 2 [P-X.1]**: Trainer is hired and trained through LRMHMRC NEO and health mentor certified **Baseline/goal:** One certified trainer / provider as a health mentor **Data Source**: HR records and	documentation **Milestone 3 Estimated Incentive Payment: $78,500** **Milestone 4 [P-4]:** Evaluate and continuously improve interventions RHP Planning Protocol Category 1 **Metric 4 [P-4.1]**: Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles. **Baseline/Goal:** Inform project improvements and problem solving in implementation. **Data Source:** Project reports including examples of how real-time data is used for	b. Denominator: The TBD number of individuals at the end of the measurement period with schizophrenia with at least two claims for an antipsychotic during the measurement period. *This would be measured at specified time intervals throughout the project to determine if there was a decrease.* **Baseline/Goal:** Improved prescription adherence **Data Source:** Claims and Encounter Data **Milestone 5 Estimated Incentive Payment: $84,927** **Milestone 6 [I-5]:** Functional	b. Denominator: The TBD number of individuals at the end of the measurement period with schizophrenia with at least two claims for an antipsychotic during the measurement period. *This would be measured at specified time intervals throughout the project to determine if there was a decrease.* **Baseline/Goal:** Improved prescription adherence **Data Source:** Claims and Encounter Data **Milestone 7 Estimated Incentive Payment: $83,572** **Milestone 8 [I-5]:** Functional Status **Metric 8 [I-5.1]:** The percentage

121988304.2.2	2.13	**2.13.1** a-e	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting **(IN SHAPE)**
Lakes Regional MHMR Center			121988304
Related Category 3 Outcome Measure(s): OD-6	121988304.3.3	IT – 6.1	Patient Satisfaction 6.1

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
HM certification. **Milestone 2 Estimated Incentive Payment: $73,839**	rapid-cycle improvement to guide continuous quality improvement. **Milestone 4 Estimated Incentive Payment: $78,500**	Status **Metric 6 [I-5.1]:** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) a. Numerator: The 40 percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. b. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** Improved functional status for 36 enrollees during program participation. **Data Source:** Standardized functional assessment	of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) a. Numerator: The ~~40 percent~~ 50% of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment. b. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** Improved functional status for 36 enrollees during program participation. Graduating 89 total participants. **Data Source:** Standardized functional assessment instruments (e.g. ANSA, CANS, etc.)

121988304.2.2	2.13	**2.13.1** a-e	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting **(IN SHAPE)**	
Lakes Regional MHMR Center				121988304
Related Category 3 Outcome Measure(s): OD-6	121988304.3.3	IT – 6.1	Patient Satisfaction 6.1	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			instruments (e.g. ANSA, CANS, etc.) **Milestone 6 Estimated Incentive Payment: $84,926**	**Milestone 8 Estimated Incentive Payment: $83,572**
Year 2 Estimated Milestone Bundle Amount: **$147,679**	Year 3 Estimated Milestone Bundle Amount: **$157,000**		Year 4 Estimated Milestone Bundle Amount: **$169,853**	Year 5 Estimated Milestone Bundle Amount: **$167,144**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* **$ 641,676**				

Project Option: 2.1.1 – Enhance/Expand Medical Homes
Unique Project Identification Number: 127278302.2.1 (Pass 1)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler (UTHSCT) is the sole academic medical center in Region 1. The organization includes a 109-bed acute care hospital, medical residency programs in Family Practice, Occupational Medicine, and Internal Medicine, and a state-of-the-art cancer treatment center, opened in 2011. University Physician Associates (UPA) comprises the physician faculty practice whose members participate in clinical care, medical and health professions training, and research to advance the institution's traditional three-pronged academic mission. UTHSCT and UPA have a long-standing history of expertise treating chest diseases including chronic respiratory illness and cardiovascular conditions. It is in this context that the project is a strategic match for UTHSCT with its mission targeted at providing excellent patient care and community health for those with chronic disease.

Intervention(s): UPA has begun the process of transforming its Family Medicine Center into a Patient Centered Medical Home (PCMH). The project proposes to enhance this transformation process with team personnel experienced in health care system engineering, and through collaboration, to extend NCQA recognition to other primary care clinics at UTHSCT. This will include the Internal Medicine Clinic on the campus of UTHSCT (Smith County) as well as the following three external clinic sites, the latter two of which are rurally located within medically underserved populations – University Health Clinic on the campus of the University of Texas at Tyler in Smith County, Gladewater in Upshur County, and Overton in Rusk County.

Need for the Project: The PCMH provides a well-coordinated home base of comprehensive care, using a team approach tailored to the needs of the patient, with an emphasis on prevention and management of chronic disease. Access to this care which is attentive to quality and safety has been shown to improve health outcomes, enhance patient and provider experience, and reduce utilization of more costly services.

Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. The region has higher numbers of uninsured residents with nearly 90 percent of the 28 counties in Region 1 (all except for three) considered as Primary Medical Care Health Professional Shortage Areas. The region has higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. Median household income is also well below that of Texas as a whole, including two of the three counties in this proposal where clinics will pursue PCMH recognition. This project aims to address Community Need 1, insufficient access to primary and specialty health care.

Target Population: During 2011, there were 11,976 patients with unique medical record numbers seen at UTHSCT, who come predominantly from the Region 1 service area, in particular the three counties where project clinics are located. Total primary care clinic visits approached 48,000 with payer mix including Medicaid 18.3 percent and self-pay 25.1 percent. Nearly 50 percent of Emergency Department (ED) visits were Medicare and Medicaid. In excess of 75 percent of hospital discharges in 2011 were from a primary care service, Family Medicine or Internal Medicine. In short, the clinics which will pursue PCMH recognition currently provide service to a population with a large share of vulnerable, indigent, and Medicaid patients.

Category 1 or 2 Expected Patient Benefits: This project is expected to enhance and expand the PCMH concept to a series of clinics within a busy academic health science center as well as to rurally based satellite clinics in the region (Smith, Upshur, and Rusk Counties). It is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Reminders for selected patient preventive services will be increased by 10% over baseline by DY5. This project is expected to cover a base patient/client population of 2,272, with unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, up to 616 patients/clients will receive or be engaged in Patient Centered Medical Home services by DY5, who did not previously have direct access to such services. The improvement milestone selected for this project to identify and reach out to patients for preventive care directly reflects the quantitative impact of the project on the population served.

Category 3 Outcomes: IT-12.~~3~~1, 12.4, 12.5 – A goal of this project is to improve utilization of well recognized preventive services such as ~~colorectal~~ breast cancer screening, pneumonia vaccination, and other USPSTF endorsed measures (cholesterol abnormalities screening), thereby reducing morbidity, mortality, and cost associated with advanced disease. Improvement target levels for DY4 and DY5 are to be determined.

Project Narrative

Project Description: The Patient Centered Medical Home (PCMH) is a concept that has evolved over several decades with input from the World Health Organization, the Institute of Medicine, several specialty care organizations, and also influenced by the Chronic Care Model. (Robert Graham Center, 2007) "The PCMH provides a primary care 'home base' for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care." (Texas Health and Human Services Commission, 2012) A recent review from the Patient-Centered Primary Care Collaborative emphasizes the description of this primary care model as "patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety." (Nielsen et al., 2012) The report states that data demonstrate the PCMH to improve health outcomes, enhance both the patient and provider experience, and reduce costly services such as unnecessary hospital and emergency department use. In so doing, it meets the Institute for Healthcare Improvement's Triple Aim for better health outcomes, better care, and lower costs. Over time, several features of the PCMH have been identified as core to its success: personal physician, physician directed medical practice, whole person orientation, care is coordinated and/or integrated, quality and safety, enhanced access, and payment reform. (Robert Graham Center, 2007; AAFP et al., 2007)

University Physician Associates (UPA) at The University of Texas Health Science Center at Tyler (UTHSCT) has begun the process of transforming its Family Medicine Center into a Level 3 PCMH, as recognized by the 2011 standards of the National Committee for Quality Assurance (NCQA, 2011). This two year process, supported by a grant from the Texas Department of State Health Services, will also implement training curriculum for residents in UTHSCT's ACGME accredited program in Family Medicine.

The **goal** of this DSRIP project is to enhance this transformation process with team personnel experienced in health care system engineering, and through collaboration, to extend NCQA recognition to other primary care clinics at UTHSCT. This will include the Internal Medicine Clinic on the campus of UTHSCT (Smith County) as well as the following three external clinic sites, the latter two of which are rurally located within medical underserved populations - University Health Clinic on the campus of the University of Texas at Tyler in Smith County, Gladewater in Upshur County, and Overton in Rusk County.

Challenges to accomplishing this goal will include potential barriers to the recruitment and retention of key team members such as those with skills in systems engineering in health care settings and physician

leaders. Other **challenges** include limited personnel resources in smaller rural clinic operations, and barriers to full implementation of electronic health records and integration with data collection systems. The project will address these challenges by providing healthcare professionals with specialized training in health care quality improvement methods as necessary, recruiting and identifying physician leaders with skill sets in this area, engagement and cross-training of current personnel in designated clinic settings, and refinement of health information technology systems currently in use at these locations.

The **expected outcome** at the conclusion of the project in DY5 will be NCQA recognition for the remaining primary care clinics noted, with intermediate outcome measures demonstrating improved patient experience. The latter is in keeping with the regional goals consistent with the Institute for Healthcare Improvement's Triple Aim for better health outcomes, better care, and lower costs.

Starting Point/Baseline: The PCMH implementation plan for the Family Medicine Center and Family Medicine Residency at UTHSCT has just been initiated beginning in June 2012 with a gap analysis to be followed by Lean training of physician champions and team members. By November of 2012, it is anticipated that the family medicine residency will have implemented PCMH residency curriculum. Therefore, there are presently no baseline numbers for percent of providers having received **training** in the project. The proposed DSRIP project will partner with the Family Medicine Center to recruit expertise in health care systems engineering to assist with their PCMH implementation, but who will also initiate extension to other UPA/UTHSCT clinics as outlined.

The following represent total primary care patient volumes for UTHSCT Clinics for calendar year 2011, which serve as a projection of **clients to be served** by these respective clinics.

Metric	**2011**
Total Primary Care Clinic Visits	47,966
Outpatient Visits to Primary Care at UTHSCT (FM physicians – 9, FM residents – 24, IM physicians – 5)	37,827
Overton Clinic (1 FM physician)	5,030
Gladewater Clinic (1 FM physician)	2,671
University Health Clinic (1 FM physician)	2,438

The patient payer mix during this time frame for both hospital (UTHSCT) and physicians (UPA) was as follows: Medicare 36.9 percent, Medicaid 18.3 percent, self-pay 25.1 percent, and commercial/other 19.7 percent. Nearly 50 percent of Emergency Department (ED) visits were Medicare and Medicaid. In excess of 75 percent of hospital discharges in 2011 were from a primary care service, Family Medicine (FM) or Internal Medicine (IM). These ED visits and discharges also originate from the patient populations of the external clinics.

In short, as the extension of the PCMH concept to the Internal Medicine Clinic and the external clinic sites will be newly implemented, there is no additional **baseline** information currently available. As DY2 and DY3 of this project will largely be focused on assembling a team, survey/gap analysis, and establishing an implementation plan, the proposed **time period** to be used as a **baseline** of **clients served** will be from calendar year 2014.

Rationale: Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. UTHSCT (with its UPA faculty) is the only academic health science center in this region drawing its patient base from the population of nearly 1.5 million Texans who reside in this corner of the state. The region has higher numbers of uninsured residents with 54 percent of these Texans either uninsured or enrolled in some form of publicly funded insurance. The region is more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. Metropolitan

counties account for just 46 percent of the region's population compared with 87 percent for all Texas residents. (Combs, 2008) Nearly 90 percent of the 28 counties in Region 1 (all except for three) are considered Primary Medical Care Health Professional Shortage Areas (U. S. Health Resources Services Administration). During 2011, there were 11,976 patients with unique medical record numbers seen at UTHSCT, who come predominantly from this service area, in particular the three counties where these clinics are located.

In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. Findings of this assessment revealed higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. (Texas DSHS, 2007) Furthermore, the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute 2011 *County Health Rankings* demonstrate how a large number of the counties in this region have health outcome rankings below the median for the state. (University of Wisconsin Population Health Institute, 2012). Median household income is also well below that of Texas as a whole including Upshur and Rusk Counties. Overall health system performance has recently been judged as being in the bottom quartile of the nation in much of Texas including Region 1. (Radley et al., 2012)

The University of Texas Health Science Center at Tyler and UPA have a long-standing history of expertise treating chest diseases including chronic respiratory illness and cardiovascular conditions. It is in this context that the project is a strategic match for UTHSCT with its mission targeted at providing excellent patient care and community health for those with chronic disease. It is well recognized that patient populations with this level of chronic disease morbidity may experience fragmented and uncoordinated care in the current health care environment. This project will expand primary care access to this level of coordinated care. The rationale for this proposal harmonizes with the rationale given for this DSRIP **project option** 2.1.1: "This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care." (Texas Health and Human Services Commission, 2012) This project will fall within **Community Need** 1 or CN.1, insufficient access to primary and specialty health care.

Given the absence of PCMH in the Internal Medicine Clinic as well as the external clinics of UPA/UTHSCT, this represents **a new initiative** as well as **enhances** implementation of the plan for the Family Medicine Center as previously described.

Using NCQA guidance/standards (NCQA, 2011), this initiative will undertake a series of steps which incorporate **core project components** to achieve NCQA recognition for the aforementioned UPA clinics as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA
  The must pass elements representing each of the six PCMH 2011 standards which align

with the core components of primary care will be pursued:

- Access during office hours
- Use of data for population management
- Care management
- Support of self-care process
- Track referrals and follow-up
- Implement continuous quality improvement

Related Category 3 Outcome Measure(s): Process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition as outlined above. These include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort. In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). These will include ~~colorectal~~ breast cancer screening (IT-12.~~3~~1), pneumonia vaccination status for older adults (IT-12.4), and another United States Preventive Services Task Force (USPSTF)-endorsed measure (IT-12.5, cholesterol abnormalities screening) as ~~determined~~ confirmed by the provider along with initial gap analysis and project planning. (USPSTF, 2013) NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as those outlined. Further, **evidence** of higher rates of chronic disease prevalence and selective cancer incidence in **Region 1** supports the selection of these particular measures and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by these clinics.

Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes clinical and educational expertise to benefit the following RHP project(s).
127278302.1.9 Pass 3b (127278302.1.2) – Increase access to specialty care for UPA
127278302.2.14 Pass 3b (127278302.2.2) – Enhance/Expand Medical Home for GSMC Internal Medicine Residency Clinic
127278302.2.19 Pass 3b (127278302.2.8) – Implement Patient Care Navigator and CHW chronic disease self-management program to reduce emergency department visits
127278302.1.4 – Increase Training of Primary Care Workforce; Capacity Building through Workforce Development: Training Community Health Workers (CHWs)
~~127278302.2.5 – Evidence-based Disease Prevention: Expand Delivery of Early Colon Cancer Treatment and Secondary Prevention Management~~
127278302.2.18 Pass3b (127278302.2.7) – Integrate Primary and Behavioral Health Care Services
The project could also have implications for **Category 4** measures such as patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.

Relationship to Other Performing Providers' Projects in the RHP: Working with Good Shepherd Medical Center in Longview, Texas (Gregg County), there will be a similar effort within the Internal Medicine Residency Clinic. Both providers work together on the residency and will participate in the learning collaborative through The Northeast Texas Center for Rural Community Health (see below).

Plan for Learning Collaborative: UTHSCT houses The Northeast Texas Center for Rural Community Health (The Center). The Center was established for the purpose of: 1) engaging in community health service activities within the Northeast Texas region and 2) enhancing, promoting, coordinating, and supporting faculty and student projects which are broad-based and intended to transform the regional health care delivery

system while improving the quality of care delivered. Specific roles of the Center will be to: 1) convene internal and external stakeholders who will participate in Regional Health Plan development and facilitation; 2) facilitate Regional Health Plan meetings and communicate function and purpose of the Regional Health Plan; 3) assist with identification of community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project; 4) coordinate efforts within the Regional Health Plan including provision of a platform and process for identifying, improving, and facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence; 5) serve as a point of contact for the Regional Health Plan with Texas Health and Human Services; 6) lend scholarly and academic assistance to the design and implementation of DSRIP projects. Serving as a facilitator for regional data transmission will be a key function of the Center, tied closely to evaluation of its success. UTHSCT will participate in a RHP-wide learning collaborative with other providers through the Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a series of clinics within a busy academic health science center as well as to rurally based satellite clinics in the region (Smith, Upshur, and Rusk Counties). This is particularly true where there has been little assessment of current practice capabilities, where there are few personnel resources, and where training in systems engineering initiatives have been limited. Yet, it is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as ~~colorectal~~ breast cancer screening, pneumonia vaccination, and other USPSTF endorsed measures (cholesterol abnormalities screening), thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. (USPSTF, 2013) The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.
- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development.

References:

American Academy of Family Physicians (AAFP), American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient centered medical home, 2007. Available at: www.medicalhomeinfo.org/Joint%20Statement.pdf (last accessed 10-02-2012).

Combs S. Texas in Focus: Upper East Texas, 2008. Available at http://www.window.state.tx.us/specialrpt/tif/uppereast/ (last accessed 10-04-2012).

Institute of Medicine. Quality through collaboration: the future of rural health. Washington, D.C.: The National Academies Press, 2005, 288 pp. Available at http://www.nap.edu/catalog/11140.html (last accessed 10-01-2012).

National Committee for Quality Assurance (NCQA). Patient-Centered Medical Home (PCMH), 2011, Available at: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx (last accessed 10-03-2012).

Nielsen M, Langner B, Zema C, Hacker T, Grundy P. Benefits of implementing the primary care patient-centered medical home: a review of cost & quality results, 2012. Patient-Centered Primary Care Collaborative, Milbank Memorial Fund 2012, 44 pp, Available at http://www.pcpcc.net/guide/benefits-implementing-pcmh (last accessed 10-01-2012).

Radley DC, How SKH, Fryer A-K, McCarthy D, Schoen C. Rising to the challenge: results from a scorecard on local health system performance, 2012. The Commonwealth Fund 2012, 102 pp. Available at http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx (last accessed 10-01-2012).

Robert Graham Center. The patient centered medical home: history, seven core features, evidence and transformational change, 2007, 29 pp. Available at: http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/pcmh.Par.0001.File.dat/PCMH.pdf (last accessed 10-02-2012).

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10-04-2012).

Texas Health and Human Services Commission (HHSC). Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

University of Wisconsin Population Health Institute. County Health Rankings: Mobilizing Action Toward Community Health – Texas, 2012. Available at http://www.countyhealthrankings.org/texas/ (last accessed 10-04-2012).

U.S. Preventive Services Task Force (USPSTF). USPSTF A and B recommendations, 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last accessed 02-21-2013).

127278302.2.1	2.1.1	2.1.1.A-D	ENHANCE/EXPAND MEDICAL HOMES	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	127278302.3.10 127278302.3.11 127278302.3.12	3.IT-12.~~3~~1 3.IT-12.4 3.IT-12.5	~~Colorectal~~ Breast Cancer Screening Pneumonia vaccination status for older adults Other USPSTF-endorsed screening outcome measure – cholesterol abnormalities screening	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 *P-4*: Staffing plan; roles/responsibilities of team members Metric 1 *P-4.1*: Schedule of training and educational opportunities Baseline/Goal: 0/1 training Data Source: Documentation of training Milestone 1 Estimated Incentive Payment (*maximum amount)*: $2,076,877 *Add more milestones and metrics as applicable*	**Milestone 2** *P-2*: Policies and systems to enhance patient access Metric 1 *P-2.1*: Performing Provider policies on medical home Baseline/Goal: 0/1 policy set Data Source: Policies and Procedures documents Milestone 2 Estimated Incentive Payment: $1,011,989 **Milestone 3** *P-11*: Identify utilization rates of preventive services Metric 1 *P-11.1*: Implement patient registry that captures preventive services utilization Baseline/Goal: Establish baseline rate Data Source: EHR Milestone 3 Estimated Incentive Payment: $1,011,989		**Milestone 4** *I-17*: Identify and reach out to patients for preventive care Metric 1 *I-17.1*: Reminders for patient preventive services Goal: Increase by 5% over baseline Data Source: Registry Milestone 4 Estimated Incentive Payment: $1,850,738	**Milestone 5** *I-17*: Identify and reach out to patients for preventive care Metric 1 *I-17.1*: Reminders for patient preventive services Goal: Increase by 10% over baseline Data Source: Registry Milestone 5 Estimated Incentive Payment: $785,373 **Milestone 6** *I-18*: Medical Home recognition by NCQA Metric 1 *I-18.1*: Medical home recognition Goal: Recognition Data Source: Documentation of recognition from NCQA Milestone 6 Estimated Incentive Payment: $785,373 Number of people potentially served in DY5 = 2,272 Volume of service anticipated in DY5 = 616
Year 2 Estimated Milestone Bundle Amount: $2,076,877	Year 3 Estimated Milestone Bundle Amount: $2,023,978		Year 4 Estimated Milestone Bundle Amount: $1,850,738	Year 5 Estimated Milestone Bundle Amount: $1,570,746
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $7,522,339				

Project Option: 2.1.1 Enhance/Expand Medical Homes
Unique Project Identification Number: 127278302.2.14 Pass 3b (127278302.2.2) (Pass 1)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler (UTHSCT) is the sole academic medical center in Region 1. It will partner with the Good Shepherd Medical Center (GSMC) in Longview, Texas, one of the largest community hospitals serving the region. GSMC is a licensed 425-bed regional referral center in East Texas for specialized care in cardiology, neurology, pulmonology, urology, gastroenterology, rehabilitation, and emergency services. The primary location is in Longview, Texas (Gregg County), but the Good Shepherd Health System also operates smaller hospital facilities in Marshall (Harrison County) and Linden (Cass County). GSMC-Longview operates a Level II trauma center with a 40 bed emergency department. In March 2010, GSMC became affiliated with the UTHSCT (sponsoring institution) to create a three-year internal medicine residency (IMR) program that has recently been accredited.

Intervention(s): The inaugural class of 18 first post-graduate year (PGY-1) residents began training in July of 2012. In the subsequent two years, GSMC will admit sequential classes of equal size such that the IMR will be operating with its full complement of 54 residents (18 PGY-1, 18 PGY-2, and 18 PGY-3). This DSRIP project, led by the faculty of University Physician Associates (UPA) at the sponsoring institution, will permit the adoption of a model of resident education which incorporates the Patient Centered Medical Home (PCMH). Specifically, the implementation of a PCMH within the IMR continuity clinic at Good Shepherd near its inception will allow optimization of delivery of coordinated care to patients. As residents often seek practice and/or employment opportunities in close proximity to their post-graduate training programs, this also creates an environment for propagating this model of care within the East Texas region.

Need for the Project: The PCMH provides a well-coordinated home base of comprehensive care, using a team approach tailored to the needs of the patient, with an emphasis on prevention and management of chronic disease. Access to this care which is attentive to quality and safety has been shown to improve health outcomes, enhance patient and provider experience, and reduce utilization of more costly services.

Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. The region has higher numbers of uninsured residents with nearly 90 percent of the 28 counties in Region 1 (all except for three) considered as Primary Medical Care Health Professional Shortage Areas. The region has higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. It is well recognized that patient populations with this level of chronic disease morbidity may experience fragmented and uncoordinated care in the current health care environment. This project will expand primary care access to the level of coordinated care which the PCMH offers. This project aims to address Community Need 1, insufficient access to primary and specialty health care.

Target Population: During calendar year 2012, there were 168,170 outpatient visits, 88,663 emergency department visits, and 36,000 admissions to GSMC. The IMR continuity clinic is new to GSMC. Therefore, there are presently no baseline numbers for percent of providers having received training in the PCMH model or similar baseline metrics at GSMC. There are four residents in clinic each day, with the exception of

Wednesday, when there are eight residents in clinic. Residents will provide service to a patient population which includes vulnerable, indigent, and Medicaid patients from the region.

Category 1 or 2 Expected Patient Benefits: This project is expected to enhance and expand the PCMH concept to a high volume residency training site at a large community hospital serving multiple counties where median household income is well below that of Texas as a whole. It is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Reminders for selected patient preventive services will be increased by 10% over baseline by DY5. This project is expected to cover a base patient/client population of 3,456, with unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, a service volume up to 864 will be delivered to patients/clients who will receive or be engaged in Patient Centered Medical Home services by DY5, and who did not previously have direct access to such services. The improvement milestone selected for this project to identify and reach out to patients for preventive care directly reflects the quantitative impact of the project on the population served.

Category 3 Outcomes: IT-12.3, 12.4, 12.5 – A goal of this project is to improve utilization of well recognized preventive services such as colorectal cancer screening, pneumonia vaccination, and other USPSTF endorsed measures (cholesterol abnormalities screening), thereby reducing morbidity, mortality, and cost associated with advanced disease. Improvement target levels for DY4 and DY5 are to be determined.

Project Narrative

Project Description: The Patient Centered Medical Home (PCMH) is a concept that has evolved over several decades with input from the World Health Organization, the Institute of Medicine, several specialty care organizations, and also influenced by the Chronic Care Model. (Robert Graham Center, 2007) "The PCMH provides a primary care 'home base' for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care." (Texas Health and Human Services Commission, 2012) A recent review from the Patient-Centered Primary Care Collaborative emphasizes the description of this primary care model as "patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety." (Nielsen et al., 2012) The report states that data demonstrate the PCMH to improve health outcomes, enhance both the patient and provider experience, and reduce costly services such as unnecessary hospital and emergency department use. In so doing, it meets the Institute for Healthcare Improvement's Triple Aim for better health outcomes, better care, and lower costs. Over time, several features of the PCMH have been identified as core to its success: personal physician, physician directed medical practice, whole person orientation; care is coordinated and/or integrated, quality and safety, enhanced access, and payment reform. (Robert Graham Center, 2007; AAFP et al., 2007)

The Good Shepherd Medical Center (GSMC) in Longview, Texas has just begun an Internal Medicine Residency (IMR) program. In March 2010, GSMC became affiliated with the University of Texas Health Science Center at Tyler (UTHSCT) to create this three-year program that has recently been accredited. Residents will train primarily at GSMC in a variety of healthcare settings including inpatient, outpatient, and emergency care. As part of this training, residents follow their own patient population in a weekly continuity clinic which has just been established. This newly formed primary care clinic provides an opportunity to transform patient care using the PCMH model while offering a training environment to residents to develop skills and competencies for implementing coordinated multidisciplinary care into their future practice. As residents

often seek practice and/or employment opportunities in close proximity to their post-graduate training programs, this also creates an environment for propagating this model of care within the East Texas region.

The **goal** of this DSRIP project is to enhance this transformation process with team personnel experienced in health care system engineering, and to secure NCQA recognition for the Internal Medicine Residency Clinic at GSMC which serves several counties in East Texas (including Gregg, Harrison, Marion, and Cass).

Challenges to accomplishing this goal will include potential barriers to the recruitment and retention of key team members such as those with skills in systems engineering in health care settings and physician leaders. Other **challenges** include limited personnel resources and barriers to full implementation of electronic health records and integration with data collection systems. The project will address these challenges by providing healthcare professionals with specialized training in health care quality improvement methods as necessary, recruiting and identifying physician leaders with skill sets in this area, engagement and cross-training of current personnel in designated clinic settings, and better understanding of health information technology systems currently in use at this location.

The **expected outcome** at the conclusion of the project in DY5 will be NCQA recognition with intermediate outcome measures demonstrating improved patient experience. The latter is in keeping with the regional goals consistent with the Institute for Healthcare Improvement's Triple Aim for better health outcomes, better care, and lower costs.

Starting Point/Baseline: The Family Medicine Center and Family Medicine Residency (FMR) at UTHSCT has just initiated implementation of the PCMH. This lengthy process began in June 2012 with a gap analysis to be followed by Lean training of physician champions and team members. By November of 2012, it is anticipated that the FMR will have initiated a PCMH residency curriculum.

The IMR at GSMC is a new program as is the IMR clinic. Therefore, there are presently no **baseline** numbers for percent of providers having received **training** in the PCMH model or similar **baseline metrics** at GSMC. The proposed DSRIP project will benefit from collaborating with the FMR at UTHSCT to take advantage of **lessons learned**. The IMR at GSMC will recruit expertise in health care systems engineering to assist with their PCMH implementation.

Due to the newness of the IMR clinic and the lack of **baseline** patient numbers, the following represent the high volume care delivered at GSMC and potentially indicative of future level of activity for the IMR clinic.

Fiscal Year (Oct. – Sept.)	**Annual Outpatient Visits**	**Annual Emergency Department Visits**	**Annual Hospital Admissions**
2010	168,170	84,430	30,612
2011	163,171	85,168	32,000
2012	170,816	88,663	36,000

As DY2 and DY3 of this project will largely be focused on assembling a team, survey/gap analysis, and establishing an implementation plan, the proposed **time period** to be used as a **baseline** of **clients served** will be from calendar year 2014. The IMR will reach its cap resident complement in July of 2014.

Rationale: Northeast Texas is a primarily rural area of the state where patients face many challenges in accessing primary care and acute care services. Nearly 1.5 million Texans reside in this corner of the state. The region has higher numbers of uninsured residents with 54 percent of these Texans either uninsured or enrolled in some form of publicly funded insurance. The region is more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. Metropolitan counties account for just 46 percent of the region's population compared with 87 percent for all Texas residents. (Combs, 2008) Nearly 90

percent of the 28 counties in Region 1 (all except for three) are considered Primary Medical Care Health Professional Shortage Areas (U. S. Health Resources Services Administration). Good Shepherd Medical Center serves a large portion of the East Texas population, concentrated in its locations of operation in Gregg, Harrison, and Cass Counties.

In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. Findings of this assessment revealed higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. (Texas DSHS, 2007) Furthermore, the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute 2011 *County Health Rankings* demonstrate how a large number of the counties in this region have health outcome rankings below the median for the state. (University of Wisconsin Population Health Institute, 2012). Overall health system performance has recently been judged as being in the bottom quartile of the nation in much of Texas including Region 1. (Radley et al., 2012) Median household income is also well below that of Texas as a whole including Gregg, Harrison, Marion, and Cass Counties.

Good Shepherd Medical Center is a licensed 425-bed regional referral center in East Texas for specialized care in cardiology, neurology, pulmonology, urology, gastroenterology, rehabilitation, and emergency services. The primary location is in Longview, Texas (Gregg County), but the Good Shepherd Health System also operates smaller hospital facilities in Marshall (Harrison County) and Linden (Cass County). GSMC-Longview operates a Level II trauma center with a 40 bed emergency department. GSMC has been recognized by HealthGrades® (2007) among America's 50 Best Hospitals with a history of clinical excellence across a broad array of services. In 2008, Good Shepherd opened the Institute for Healthy Living, a 75,000-square-foot medically-integrated wellness center.

GSMC has recently admitted its first class of an Internal Medicine Residency (IMR). Through its partnership with UTHSCT as the sponsoring institution for the residency, GSMC sought to collaborate as a community health system with this highly reputable academic health science center to push the envelope of high quality, cutting edge health care delivery in East Texas. The residency program has received accreditation from the Accreditation Council for Graduate Medical Education (ACGME) and creates an environment of training, scholarly inquiry, professionalism, and pursuit of quality improvement in health care delivery.

The inaugural class of 18 first post-graduate year (PGY-1) residents began training in July of 2012. In the subsequent two years, GSMC will admit sequential classes of equal size such that the IMR will be operating with its full complement of 54 residents (18 PGY-1, 18 PGY-2, and 18 PGY-3). Residents see patients in their outpatient clinic one afternoon per week. Their hours are 1-5 p.m. on Mondays, Wednesdays, Thursdays, and Fridays. There are four residents in clinic each day, with the exception of Wednesday, when there are eight residents in clinic. Resident supervision occurs through Good Shepherd core faculty as well as the Program Director, Emmanuel Elueze, MD, PhD, FACP, who is a fulltime faculty member at UTHSCT (Associate Professor of Medicine).

This DSRIP project, lead by the faculty of University Physician Associates (UPA) at the sponsoring institution, will permit the adoption of a model of resident education currently moving forward within the FMR at UTHSCT. Specifically, the implementation of a PCMH within the IMR continuity clinic at Good Shepherd near its inception will allow optimization of delivery of coordinated care to patients. At the same time, it will offer the opportunity for instruction and experience to IM residents in the transformation of care to the model of the PCMH. The Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home, currently being used with the FMR at UTHSCT, will be adopted for the purpose of establishing the competencies that IM residents should strive for and achieve in the course of their training. (AAFP et al., 2010) These Joint Principles provide a cross-walk between the Joint Principles of the PCMH and these competencies.

It is well recognized that patient populations with this level of chronic disease morbidity may experience fragmented and uncoordinated care in the current health care environment. This project will expand primary care access to the level of coordinated care which the PCMH offers. The rationale for this proposal harmonizes with the rationale given for selected DSRIP **project option** 2.1.1: "This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care." (Texas Health and Human Services Commission, 2012) This project will fall within **Community Need** 1 or CN.1, insufficient access to primary and specialty health care. This is **a new initiative** focused on **expansion/enhancement** of the PCMH model.

Using NCQA guidance/standards (NCQA, 2011), this initiative will undertake a series of steps which incorporate **core project components** to achieve NCQA recognition for the aforementioned IMR clinic at GSMC as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Adopt the Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA

The must pass elements representing each of the six PCMH 2011 standards which align with the core components of primary care will be pursued: 1) Access during office hours; 2) Use of data for population management; 3) Care management; 4) Support of self-care process; 5) Track referrals and follow-up; and 6) Implement continuous quality improvement.

Related Category 3 Outcome Measure(s): Process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition as outlined above. These include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort. In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). These will include colorectal cancer screening (IT-12.3), pneumonia vaccination status for older adults (IT-12.4), and another United States Preventive Services Task Force (USPSTF)-endorsed measure (IT-12.5, cholesterol abnormalities screening) as ~~determined~~ confirmed by the provider along with initial gap analysis and project planning. (USPSTF, 2013) NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as those outlined. Further, **evidence** of higher rates of chronic disease prevalence and selective cancer incidence in **Region 1** supports the selection of these particular measures and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by the GSMC IMR clinic.

Relationship to other Projects:

As a project sponsored by an academic medical center affiliate it is inter-related and contributes clinical and educational expertise to benefit the following RHP project(s).
127278302.2.1 – Enhance/Expand Medical Home for UPA Primary Care Clinics
127278302.2.19 Pass 3b (127278302.2.8) – Implement Patient Care Navigator and CHW chronic disease self-management program to reduce emergency department visits
127278302.1.4 – Increase Training of Primary Care Workforce; Capacity Building through Workforce Development: Training Community Health Workers (CHWs)
127278302.2.5 – Evidence-based Disease Prevention: Expand Delivery of Early Colon Cancer Treatment and Secondary Prevention Management
127278302.2.18 Pass3b (127278302.2.7) – Integrate Primary and Behavioral Health Care Services
The project could also have implications for **Category 4** measures, e.g., patient-centered health care, patient satisfaction, and potentially preventable admissions/re-admissions/complications.

Relationship to Other Performing Providers' Projects in the RHP: As noted previously, this project will benefit from lessons learned from UTHSCT's FMR. Both providers work together on the IMR and will participate in the learning collaborative through The Northeast Texas Center for Rural Community Health (see below).

Plan for Learning Collaborative: The Northeast Texas Center for Rural Community Health (The Center) was established for the purpose of: 1) engaging in community health service activities within the Northeast Texas region and 2) enhancing, promoting, coordinating, and supporting faculty and student projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. Specific roles of the Center will be to: 1) convene internal and external stakeholders who will participate in Regional Health Plan development and facilitation; 2) facilitate Regional Health Plan meetings and communicate function and purpose of the Regional Health Plan; 3) assist with identification of community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project; 4) coordinate efforts within the Regional Health Plan including provision of a platform and process for identifying, improving, and facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence; 5) serve as a point of contact for the Regional Health Plan with Texas Health and Human Services; 6) lend scholarly and academic assistance to the design and implementation of DSRIP projects. Serving as a facilitator for regional data transmission will be a key function of the Center, tied closely to evaluation of its success. GSMC will participate in a RHP-wide learning collaborative with other providers through the Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a new IMR continuity clinic which serves a vulnerable rural population. It is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as colorectal cancer screening, pneumonia vaccination, and other USPSTF endorsed measures (cholesterol abnormalities screening), thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. (USPSTF, 2013) The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.

- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development and residency education.

References:

American Academy of Family Physicians (AAFP), American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient centered medical home, 2007. Available at: www.medicalhomeinfo.org/Joint%20Statement.pdf (last accessed 10-02-2012).

American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home, December 2010. Available at: http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/educ-joint-principles.pdf (last accessed 10-07-2012).

Combs S. Texas in Focus: Upper East Texas, 2008. Available at http://www.window.state.tx.us/specialrpt/tif/uppereast/ (last accessed 10-04-2012).

Institute of Medicine. Quality through collaboration: the future of rural health. Washington, D.C.: The National Academies Press, 2005, 288 pp. Available at http://www.nap.edu/catalog/11140.html (last accessed 10-01-2012).

National Committee for Quality Assurance (NCQA). Patient-Centered Medical Home (PCMH), 2011, Available at: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx (last accessed 10-03-2012).

Nielsen M, Langner B, Zema C, Hacker T, Grundy P. Benefits of implementing the primary care patient-centered medical home: a review of cost & quality results, 2012. Patient-Centered Primary Care Collaborative, Milbank Memorial Fund 2012, 44 pp, Available at http://www.pcpcc.net/guide/benefits-implementing-pcmh (last accessed 10-01-2012).

Radley DC, How SKH, Fryer A-K, McCarthy D, Schoen C. Rising to the challenge: results from a scorecard on local health system performance, 2012. The Commonwealth Fund 2012, 102 pp. Available at http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx (last accessed 10-01-2012).

Robert Graham Center. The patient centered medical home: history, seven core features, evidence and transformational change, 2007, 29 pp. Available at: http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/pcmh.Par.0001.File.dat/PCMH.pdf (last accessed 10-02-2012).

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10-04-2012).

Texas Health and Human Services Commission (HHSC). Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

University of Wisconsin Population Health Institute. County Health Rankings: Mobilizing Action Toward Community Health – Texas, 2012. Available at http://www.countyhealthrankings.org/texas/ (last accessed 10-04-2012).

U.S. Preventive Services Task Force (USPSTF). USPSTF A and B recommendations, 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last accessed 02-21-2013).

127278302.2.14 Pass 3b (127278302.2.2)	2.1.1	2.1.1.A-D	ENHANCE/EXPAND MEDICAL HOME	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	127278302.3.39 Pass 3b (127278302.3.13)	3.IT-12.3	Colorectal Cancer Screening	
	127278302.3.40 Pass 3b (127278302.3.14)	3.IT-12.4	Pneumonia vaccination status for older adults	
	127278302.3.41 Pass 3b (127278302.3.15)	3.IT-12.5	Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening)	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 *P-4*: Staffing plan; roles/responsibilities of team members Metric 1 *P-4.1*: Schedule of training and educational opportunities Baseline/Goal: 0/1 training Data Source: Documentation of training Milestone 1 Estimated Incentive Payment (*maximum amount)*: $2,221,309 *Add more milestones and metrics as applicable*	**Milestone 2** *P-2*: Policies and systems to enhance patient access Metric 1 *P-2.1*: Performing Provider policies on medical home Baseline/Goal: 0/1 policy set Data Source: Policies and Procedures documents Milestone 2 Estimated Incentive Payment: $919,134.50 **Milestone 3** *P-11*: Identify utilization rates of preventive services Metric 1 *P-11.1*: Implement patient registry that captures preventive services utilization Baseline/Goal: Establish baseline rate Data Source: EHR Milestone 3 Estimated Incentive Payment: $919,134.50	**Milestone 4** *I-17*: Identify and reach out to patients for preventive care Metric 1 *I-17.1*: Reminders for patient preventive services Goal: Increase by 5% over baseline Data Source: Registry Milestone 4 Estimated Incentive Payment: $1,697,719	**Milestone 5** *I-17*: Identify and reach out to patients for preventive care Metric 1 *I-17.1*: Reminders for patient preventive services Goal: Increase by 10% over baseline Data Source: Registry Milestone 5 Estimated Incentive Payment: $795,121 **Milestone 6** *I-18*: Medical Home recognition by NCQA Metric 1 *I-18.1*: Medical home recognition Goal: Recognition Data Source: Documentation of recognition from NCQA Milestone 6 Estimated Incentive Payment: $795,121 Number of people potentially served in DY5 = 3,456 Volume of service anticipated in DY5 = 864
Year 2 Estimated Milestone Bundle Amount: $2,221,309	Year 3 Estimated Milestone Bundle Amount: $1,838,269	Year 4 Estimated Milestone Bundle Amount: $1,697,719	Year 5 Estimated Milestone Bundle Amount: $1,590,242

127278302.2.14 Pass 3b (127278302.2.2)	**2.1.1**	**2.1.1.A-D**	**ENHANCE/EXPAND MEDICAL HOME**	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	127278302.3.39 Pass 3b (127278302.3.13)	3.IT-12.3	Colorectal Cancer Screening	
	127278302.3.40 Pass 3b (127278302.3.14)	3.IT-12.4	Pneumonia vaccination status for older adults	
	127278302.3.41 Pass 3b (127278302.3.15)	3.IT-12.5	Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening)	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $7,347,539				

Project Option 2.10.1 - Implement a Palliative Care Program to Address Patients with End-of-Life Decisions and Care Needs
Unique Project Identifier Number: 127278302.2.15 Pass 3b (127278302.2.3 **(**Pass 1))
Performing Provider/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler (UTHSCT) is the sole academic medical center in Region 1. The organization includes a 109 bed acute hospital, and residency programs in family, occupational, and internal medicine (located at Good Shepherd Medical Center (GSMC), and three satellite clinics to improve access for rural residents in the service area. The University Physician Associates (UPA) comprises the faculty who participate in research, clinical care, and health professions training to advance the institution's mission. Good Shepherd Medical Center in Longview, TX is a licensed 425-bed acute care regional referral center.

Intervention: This new initiative will deploy two multi-disciplinary palliative care teams to demonstrate a re-design of care delivery models for ambulatory and in-patient care. One team will assess pain levels and treat a cohort of UPA clinic patients who have chronic debilitating diseases; a second team will be based at GSMC to consult on pain assessment/treatment for a population of in-patients. Primary care physicians will receive training to enhance pain assessment skills and current pharmacology protocols.

Need for the Project: Currently, neither organization systematically implements pain management protocols; each recognizes that effective whole person pain management will reduce readmissions, ED visits, ICU admissions, of stay, and cost of care. The region has a higher age-adjusted invasive cancer incidence rate, chronic disease and chronic disease mortality than the statewide average. A baseline of patients comprising the target population will be established in DY2.

Target Population: The target population includes ambulatory patients with debilitating diseases and in hospital patients who would benefit from pain assessment and treatment plan. Approximately 50% of patients are either Medicaid eligible or self-pay, so we expect they will comprise about half of the consults.

Category 2 Expected Patient Benefits: The project seeks to enhance palliative care consultation/services by X% (TBD) DY4 compared with the DY2 baseline and by X% (TBD) in DY5 compared to the baseline. An additional benefit will be derived from improved pain management delivered by non-project team physicians resulting from palliative care training provided as part of the project. Using staffing guidelines developed by Hospice of America for inpatient and home-based services, and without a baseline being established as yet for this new, innovative approach it is estimated that 334 patients would be referred for palliative care services as defined in the project over the 3 year demonstration period. With the

interdisciplinary team approach, each patient/family would receive an average of 3 services or an estimated service volume of 1,000.

Category 3 Outcomes: IT-13.1, increase the number of palliative care patients who are screened for pain and receive an assessment for treatment within 24 hours by X% (TBD) in DY4 and by a X% (TBD) in DY5compared to the baseline established in DY2. IT.13.2 , increase the number of palliative care patients whose treatment preferences are documented in the chart by X% (TBD) in DY4 and by a X% (TBD) in DY5compared to the baseline established in DY2. IT.13.5 increase the number of palliative care patients whose desire to discuss spiritual issues is documented in their chart by X% (TBD) in DY4 and by a X% (TBD) in DY5compared to the baseline established in DY2.

Project Narrative

Project Description: The population of patients for whom palliative care is appropriate is not well-defined. (Kaasa, Loge 2003) Typically hospice programs employ a multi-disciplinary team to deliver comfort care to address the physical, emotional pain, and suffering for patients with a life expectancy of six months or less. The intention of palliative care however, is to improve the quality of life for patients who have a serious illness by managing symptoms and providing support for the patient and family through and following the treatment process. This may be initiated as early as the time of diagnosis (National Hospice & Palliative Care Organization, 2012) Palliative care services may be provided for patients with serious and debilitating diseases either in the home or hospital. Evidence suggests that palliative care for hospitalized patients can achieve improved quality of life for patients whether discharged alive or expire in the hospital, as well as a significant reduction in costs. (Morrison, et.al 2008) A study that analyzed Medicare beneficiaries cost of care in the last year of life concluded that the "high cost of dying is just the cost of caring for severe illness and functional impairment." (Hogan et al. 2001) It is estimated that the average cost per day for a patient in ICU is $10,000. Interestingly, cancer care for patients near the end of life is more aggressive than patients prefer. (Morden, et.al 2012)

The transformative project proposed here will demonstrate the effectiveness of two models of palliative care delivery that each addresses **RHP 1 goals of** 1) improved quality of care and patient satisfaction, 2) reduction in health care costs, and 3) improved health care access by establishing multi-disciplinary teams. Each strategy will be implemented for patient populations served by two separate institutions and requiring different levels of care. The palliative care team supporting University Physician Associates (UPA) based at the UTHSCT will identify and engage a multi-disciplinary supportive care team to work with patients who have a chronic, debilitating disease. The Supportive Care Team will function to provide a comprehensive palliative care program according to The World Health Organization's (WHO) definition of palliative care (Sepulveda et. al 2002) in order to improve the quality of life for patients with life-threatening conditions and their families. Limited life expectancy will not be a requirement for referral to this team. By educating and reiterating information about the disease process, while providing emotional support to patients/families, it is anticipated that

the use of the ED for acute episodes and hospitalizations for anticipated end-of-life symptoms will be substantially reduced.

The second strategy to demonstrate an effective model of care for primarily rural residents of northeast TX is to implement a palliative consultation team for patients hospitalized at Good Shepherd Medical Center (GSMC). This will include developing a pain management education program for practicing health care professionals and physicians in training. This project will be implemented as a collaborative effort and learning collaborative between the University Physician Associates at the UTHSCT and Good Shepherd Medical Center (GSMC) in Longview, TX. Although separated by about 40 miles and with similar patient demographics, there will be no overlap or duplication of care for patients served this project.

The **goal** of this project is to implement two models of palliative care delivery using multi-disciplinary, supportive care teams to address physical, emotional, and spiritual discomfort including advanced care planning for patients and their families who are suffering from chronic, debilitating disease.

Challenges to complete project implementation include changing the mindset of physicians. The emphasis of most medical education programs is exclusively on disease identification and treatment. It has more recently been recognized (although not universally accepted) that relief of suffering is a cornerstone of medical practice and that death is a natural and inevitable part of life. Given the shortage of healthcare providers in the region, it is a **challenge** for both ambulatory practices and hospitals to prioritize palliative care services. The high rate of chronic disease in the region, re-hospitalizations for chronic conditions such as CHF, ESRD, and COPD indicates that a substantial number of patients would have a better experience of care, better outcome, and at a cost savings to the system if palliative care services were available to them.

The **expected outcome** at the conclusion of the project in DY5 is the expanded acceptance of palliative care services for both ambulatory and hospitalized patients by health care professionals in TX HHSC region 1. It is anticipated that this program will result in fewer ED visits for pain management, a reduction in hospitalizations for treatment of pain and end of life care resulting in positive perceptions of quality of care by patients, families, and health care professionals.

Starting Point/Baseline: An assessment of hospital readmissions at the UTHSCT in early 2011 revealed that a significant number of readmissions were potentially preventable if the patients and their families had received 1) ongoing education about the disease process, 2) assistance with advanced care planning for anticipated stages of physical limitations, cognitive impairment, and end-of-life treatment preferences, 3) received ongoing monitoring of pain management, 4) emotional and spiritual support, 5) more thorough education about their disease process. The UTHSCT has identified a physician champion and supportive care team members who will complete the Palliative Care leadership training offered by the Center to Advance Palliative Care, Birmingham, AL in DY2. This will position the team to initiate the internal planning and processes required to implement the Supportive Care Team model proposed. **No baseline** of patients for referral to supportive care exists; an important component of DY2 planning process will be the establishment of the patient profile and referral process.

A similar evaluation of hospital admissions, length of stay, ED visits and ICU admissions at the GSMC pointed to a need for an updated approach to pain management for patients and education about current best practices for pain pharmacology with physicians. A physician champion has been identified who has expertise in palliative care. Currently, **there is no baseline** number against which to assess the improvement metrics. The project planning process in DY2 will determine the patient profile and protocols to assure that palliative care is integrated into the patient's care plan following the Palliative Care Consultation Service modeled after the program(s) reported by the California HealthCare Foundation (2007)

This proposed approach to palliative care is a **new initiative**, therefore; the baseline of patients who will be served and the targeted number of healthcare professions who will complete palliative care training will be established in DY3.

Rationale: The population served by the UPA affiliated with the UTHSCT, the academic medical center for the region and Good Shepherd Medical Center, a safety net hospital, is much more rural than Texas as a whole with a much larger share (15 per cent) of residents over the age of 65. (Combs 2008-b) The region has a higher than average prevalence of certain chronic diseases; admission rates for COPD, CHF, and mortality rates from heart disease and chronic lung disease are among the highest in the state. (Combs 2008-b, Jackson, Suzuki et al. 2011-a, Jackson, Suzuki et al. 2011-b) The Northeast Texas RHP plan verifies that the region has high prevalence of chronic disease and high mortality rates for chronic disease and cancer. The region has a higher age-adjusted invasive cancer incidence rate than the statewide average. (2012 Texas Cancer Registry)

In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. In addition to higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable population, and more people in poverty than the state as a whole, the region also experiences high rates of preventable hospitalizations.

This DSRIP project led by faculty of UPA at the sponsoring institution and collaboratively with the Internal Medicine faculty at GSMC will undertake **Project Option 2.10.1** to: Implement a Palliative Care Program to support patients with end-of-life decisions and care needs. Together these two health care organizations routinely serve residents from more than half the counties in the region. This project addresses the region 1 RHP **Community Need CN.3** High rates of chronic disease and **CN. 6** Efficiency and effectiveness of health care delivery. This transformative program will be implemented in concert with the **required core project components**:

a) In DY2 a multi-disciplinary work group comprised of representatives from both collaborating partner organizations to include business managers, physician champions, nurses, social workers, case managers, and Quality Improvement staff will be assembled. They will use the planning model established by the Center to Advance Palliative Care (CAPC) to develop a business case for palliative care for ambulatory patients who are suffering from serious, chronic and debilitating illness. That plan will be implemented for patients who use the UPA clinics. The work group will also utilize CAPC, the National Hospice and Palliative Care Association and

other established "best practices" **training materials** to develop protocols and processes for a palliative care for ambulatory patients.

Models described by Pantilat, et al. (2007) regarding the use of palliative consultation teams for hospitalized patients will serve as a reference for building the business case for a palliative care consultation program at Good Shepherd Medical Center for inpatient care. Further, the work group will confer on the development of protocols and subsequent **staff and physician training** for in-hospital palliative care consultation, data capture, and quality improvement measures including patient perception of pain control, and quality of care.

b) The Supportive Care Team working with the UPA clinics will include a physician champion, nurse navigator, medical social worker/licensed personal counselor, and 2 Community Health Workers. This team will focus on providing proactive support for patients and their families at a point in the disease process where management of physical, emotional and spiritual pain can be assessed and treated in order to eliminate unnecessary suffering, inappropriate use of ED, and potentially preventable hospitalizations. Referrals to the supportive care team will be facilitated by the clinic case manager. The Nurse Navigator will receive referrals from clinic managers through regular meetings for case review. Patients with single or co-morbid diagnoses (CHF, Parkinson's Disease, COPD, ESRD, and certain cancers) may be referred to the supportive care team. A patient/family meeting will be conducted by the nurse or social worker to assess status, concerns, and issues to guide the supportive care plan development. Education about the disease process will be included for all cases. The standard intake information gathered by the nurse or social worker for each patient/family including their goals, will serve as the basis for developing the care plan for discussion and agreement on team assignments for that patient/family. A common goal for the patient will be established and each team member will work to achieve that goal. The care plan will be shared with the patient and family as well as the referring clinician. The care plan will include ongoing pain assessment through phone and in-person visits and the schedule of visits (phone, in-home, and in-clinic). The care plan and progress notes will be shared with the primary care provider and included in the patient's chart. The palliative team will jointly determine the leader for each case.

The Palliative Care consultation team for GSMC will hold regular team meetings with the hospital case manager(s)/discharge planners to assess ongoing patient needs. The team will function with support from administration and medical staff leadership to develop guidelines for specific conditions or situations such as pain management and advanced care planning; establish protocols to guide care in certain clinical situations such as withdrawal of mechanical ventilation; develop policies regarding artificial nutrition in patients with severe dementia or palliative sedation; educate staff at all levels throughout the hospital on palliative care topics; assure data collection and management includes comprehensive patient information, clinical outcomes, patient and family satisfaction, and referring clinician satisfaction; provide staff support to cope with difficult cases and support each other in self-care of staff.

The supportive care team nurse navigator will maintain communication with the patient and family and; follow-up with hospital discharge planners and post-hospitalization caregivers – whether nursing home, hospice or home health agency to assure the palliative care plan is in place prior to discharge and monitored for two weeks following discharge.

c) The palliative care team protocols will include the periodic administration of a standardized patient/family experience survey to assess perceptions of quality of care, pain and symptom management, and patient/family centeredness of care such as CAHPS for the in-patient program and CG-CAHPS for the ambulatory care patients. Additional survey questions will address the patient's preference for end-of life treatment and perception of pain, and discussions related to spiritual/religion issues. Results from these surveys will be used by the supportive care team for rapid cycle improvement and other quality improvement measures.

d) Quality improvement assessment will be integrated into the operations of each team. Team members with 1) the supportive care team (UPA) and 2) palliative consultation care team will convene by phone or web-based meeting bi-weekly following enrollment of the first patient and at least monthly thereafter for the duration of the demonstration project. The teams may convene more often as needed/indicated. The team meetings will address the status of each patient on the caseload, review symptom management, family issues, and care plan compliance. Revisions to the care plan will be made, implemented and documented by agreement of the team. Resources outside the teams will be invited to meetings on a quarterly basis to provide additional perspectives, potential solutions, and recommendations for revising protocols as well as positive feedback on accomplishments. These guests may include a referring clinician, family member, or service organization to which patients are referred (nursing home, home health agency, etc.).

Related Category 3 Outcome Measure(s): Use of the ED or hospitalizations for palliation is both costly and stressful for the patient and family. This project will demonstrate that appropriate, evidence-based physical, emotional, and spiritual pain management delivered by multi-disciplinary team results in documented improved quality of care and better patient outcomes as described in the project narrative. Morrison (2008) report that in-hospital palliative care consultation reduced costs of expensive and unnecessary tests by shifting the focus from averting death at all costs to patient comfort. For ambulatory patients Brumley (2003) found high levels of satisfaction among palliative home care patients with a significant reduction in ED visits, hospital stays, skilled nursing home stays, and physician visits compared with a cohort not enrolled in a palliative care program. This is the rationale for selecting three non-standalone measures from Outcome Domain: **OD-13** Palliative Care. Improvement targets include: **IT-13.1** pain level screening documentation and evidence clinical assessment within 24 hours; **IT-13.2** as a result of continuing education for health professionals and deployment of palliative care teams, there will be an increase in documentation in patient's chart indicating the life-sustaining treatment preferences; and **IT-13.5** there will be an increase in the percent of palliative care patients whose charts reflect that their spiritual/religious concerns have been acknowledged and addressed or that the patient chose not to discuss these issues.
The project has implications for **Category 4** measures, especially patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.

Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure, clinical, and educational expertise to benefit the following RHP project(s):

127278302.1.4: Increase Training of Primary Care Workforce; Capacity Building through Workforce Development: Training Community Health Workers. CHWs are important members of the palliative care team.
127278302.2.17 Pass 3b (127278302.2.6) Apply Process Improvement Methodology to Improve Quality/Efficiency; CHF is a common focus; two of the four are collaborating partners for this palliative care project, it is likely that CHF patients will be among the patients enrolled for palliative care services.
127278302.2.1 and 127278302.2.14 Pass 3b (127278302.2.2) The Patient Centered Medical Home model is being expanded to include the UPA clinics in Overton, Gladewater, and eastern Smith county. The internal medicine department at GSMC is also pursuing implementation of the PCMH standards. It is likely that some patients using these clinics will benefit from being referred to the supportive care team.

Relationship to Other Performing Providers' Projects in the RHP: Successes and lessons learned will be shared by other RHP members through the regional learning collaborative described below.

Plan for Learning Collaborative: The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health (The Center). The Center will 1) convene internal and external Regional Health Plan stakeholders; 2) facilitate Regional Health Plan meetings; 3) assist with identification of community needs, healthcare challenges and the metrics associated with each project; 4) coordinate efforts within the Regional Health Plan including a process for identifying, improving, and facilitating principles of best evidence; 5) lend scholarly and academic assistance to the design and implementation of DSRIP projects. UTHSCT will utilize the Center as the clearinghouse for best practices and lessons learned through DSRIP project implementation.

Project Valuation: Ineffective pain management for patients with chronic debilitating diseases results in inappropriate use of EDs, unnecessary hospitalizations, and poor quality of care (Morden 2012). Valuation of this project reflects the costs to transform health care delivery, the added value of this project will be measured in improved quality of care and patient satisfaction. In addition, training primary care physicians in practice and in training, as members of a multidisciplinary team will have far reaching benefits for patient care beyond this region. The valuation of this ambitious transformative demonstration project is justified as follows:

- Involves a close collaboration between an academic health science center and a large safety net hospital thereby reaching poor, underserved individuals
- Serves residents from a significant portion (almost half) of the counties in the region
- Demonstrates a model with the potential for significant health care system cost savings
- Transforms the delivery of care by training physicians to deliver comfort care rather than costly, unnecessary tests and procedures
- Contributes expertise to scale all or part of the project to other institutions through the regional Learning Collaborative.

References:

Brumley RD, Enguidanos S, Cherin DA. Effectiveness of a home-based palliative care program for end-of-life. Journal of Palliative Medicine, Oct 2003, 5(5) 715-724.

Dartmouth Atlas of Healthcare. http://www.dartmouthatlas.org (last accessed 10/13/2012**)**

Gore JM, Brophy CJ, Greenstone MA, How well do we care for patients with end state chronic obstructive pulmonary disease? A comparison of palliative care and quality of life in COPD and lung cancer. Thorax 2012; 55:1000-1006

Greenhalgh et al. diffusion of innovations in service organizations: systematic review and recommendations. The Milbank Quarterly 2004 Dec;82(4):581-629

Morrison SR, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med. 2008; 168(16):1783-1790.

Kaasa S, Loge JH Quality of life in palliative care: principles ad practice. Palliative Medicine 2003 17:11-20.

Morden, ME, Chang CH, Jacobson JO, Berke EM, Bynum JPW, Murray KM, Goodman DC. End-of-life care for medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff Apr 2012, 81(4):786-796.

The National Hospice and Palliative Care Organization. http://www.nhpco.org (last accessed 10/10/12)

Pantilat SZ, Rabow MW, Kerr KM, Markowitz AJ. Palliative care in california: an overview of hospital-based programs. May 2007. The California Health Foundation www.chcf.org.

Teno JM, Clarridge BR, Casey V. et al. Family perspectives on end-of-life care at the last place of care. JAMA2004;291(1)88-93.

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.stae.tx.us/easttexas/reports.shtm (last accessed 10/4/2012).

World Health Organization. *The first ten years of the World Health Organization*. WHO, 1958

127278302.2.15 Pass 3b 127278302.2.3 Pass 1	2.10.1	2.10.1 A-D	**Implement a Palliative Care Program to Address Patients with End-of-Life Decisions and Care Needs**
University Physician Associates			127278302
Related Category 3 Outcome Measure(s):	127278302.3.42 Pass 3b (127278302.3.16)	IT-13.1	Percent improvement in pain assessment (NQF-1637)
	127278302.3.43 Pass 3b (127278302.3.17)	IT-13.2	Percent improvement in treatment preferences (NQF-1641)
	127278302.3.44 Pass 3b (127278302.3.18)	IT-13.5	Percent improvement in discussion of spiritual/religious concerns (NQF-1647)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1 Develop hospital-specific business case for palliative care & conduct planning necessary to implement palliative care program Metric 1 P-1.1: Business case Baseline/Goal: Business Case Data Source: Documentation of planning; Business case report Milestone 1 Estimated Incentive Payment (*maximum amount)*: $1,621,383	**Milestone 2** P-5: Implement Palliative Care Program Metric 1 P-5.1: Implement Comprehensive Palliative Care Program Goal: Operational Plan, Data Source: Palliative care program Milestone 2 Estimated Incentive Payment: $1,353,522.50 **Milestone 3** P-6: Increase the number of palliative care consults Metric 1 P-6.I: Palliative care consults meet established program targets Baseline/Goal: TBD Data Source: Medical records, palliative care program database Milestone 3 Estimated Incentive Payment: $1,353,522.50	**Milestone 4** P-6: Increase the number of palliative care consults Metric 1 P-6.1:Palliative care consults meet established targets Goal: Increase consults by 10% over baseline Data Source: Medical records, palliative care program database Milestone 4 Estimated Incentive Payment: $1,195,751 **Milestone 5** ~~I-11: Increase % of palliative care patients screened positive for pain with clinical assessment within 24 hours~~ I-12 Implement a patient-family experience survey regarding the quality of care pain/symptom management, and degree of patient/family centeredness in care and improve scores over time Metric 1 ~~I-11.2Pain assessment (NQF-1637)~~ I-12.1- Survey developed and implemented Goal: ~~Increase palliative care patients screened positive for pain with clinical assessment within 24 hours~~	**Milestone 6** ~~I-11: Increase % of palliative care patients screened positive for pain with clinical assessment within 24 hours~~ I-12 Implement a patient-family experience survey regarding the quality of care pain/symptom management, and degree of patient/family centeredness in care and improve scores over time Metric 1 ~~I-11.2: Pain assessment (NQF-1637)~~ Survey scores increased over time Goal: ~~Increase patients screened positive for pain with clinical assessment~~ Improve patient/family survey scores by 15% over baseline Data Source: ~~medical records, palliative care program database~~ Patient/family survey scores Milestone 6 Estimated Incentive Payment: $2,015,569

127278302.2.15 Pass 3b 127278302.2.3 Pass 1	2.10.1	2.10.1 A-D	**Implement a Palliative Care Program to Address Patients with End-of-Life Decisions and Care Needs**
University Physician Associates			127278302
Related Category 3 Outcome Measure(s):	127278302.3.42 Pass 3b (127278302.3.16)	IT-13.1	Percent improvement in pain assessment (NQF-1637)
	127278302.3.43 Pass 3b (127278302.3.17)	IT-13.2	Percent improvement in treatment preferences (NQF-1641)
	127278302.3.44 Pass 3b (127278302.3.18)	IT-13.5	Percent improvement in discussion of spiritual/religious concerns (NQF-1647)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Improve survey scores by 10% over baseline Data Source: ~~medical records, palliative care program database~~ Result of survey scores Milestone 5 Estimated Incentive Payment: $1,195,751	Estimate volume of services at 1000 for 334 patients over the project period
Year 2 Estimated Milestone Bundle Amount: $1,621,383	Year 3 Estimated Milestone Bundle Amount: $2,707,045	Year 4 Estimated Milestone Bundle Amount: $2,391,502	Year 5 Estimated Milestone Bundle Amount: $2,015,569
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $8,735,499			

Project Option 2.2.1: Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – (Pediatric Asthma)
Unique Project Identification Number – 127278302.2.16 Pass 3b (127278302.2.4 (Pass 1))
Performing Provider: UTHSCT - MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler (UTHSCT) is the sole academic medical center in Region 1. The organization includes a 109 bed acute hospital, three medical residency programs, and clinic services for primary and specialty care; it is a recognized leader in lung disease and respiratory research. CHRISTUS St. Michael's, is a 312 bed acute hospital based in Texarkana, TX. Together, these organizations will reach the underserved population in twelve counties in their respective service areas.

Intervention: The two organizations will ~~collaborate~~ partner on this innovative and expanded demonstration project to diagnosis and support self-management skills among their pediatric populations with acute asthma/allergies respiratory episodes in order to reduce ED visits and hospitalizations. This project will deploy two mobile teams, under the direction of an Immunology/Allergy specialist, to assess children with a history of breathing problems for a diagnosis and treatment plan. Each team will use CHWs to work with patients/families to minimize triggers and reinforce self-management skills.

Need for the Project: Currently, neither organization has an outreach program to identify pediatric patients with asthma and/or chronic respiratory problems. Between 1980 and 1994, the prevalence of asthma in the U.S. increased 75% overall, and 74% among children 5 to 14 years of age. In 2002, asthma treatment costs in the United States were $12 billion, and the estimated cost of treating asthma for those younger than 18 years of age was $6 billion per year. Christus St. Michael's hospitalization use for pediatric asthma patients (Feb. 2011 – June 2012) was 309 ED visits, 49 in-patient stays, and five observation stays. This demonstration project addresses **CN 1**. Insufficient access to primary and specialty care, **CN 3**. high rates of chronic disease, and **CN 5**. Inappropriate use of emergency department.

Target Population: The target population for this project is children who have uncontrolled and/or undiagnosed asthma or chronic respiratory problems. Based on the payer mix for the two organizations, it is expected that 60% of the children who gain access to care through this project will be Medicaid eligible/indigent. Referral to a primary care provider (as needed) will also provide access to care for family members. Based on extrapolation from current patient populations, we estimate that about 1500 children will served by this project through DY5 and on average, each child will receive 3 services.

Category 2 Expected Patient Benefits: A target population baseline will be established in DY 2. This project seeks to increase the number of unique patients served by this program by 5% over baseline in DY4 and 10% over baseline in DY5. A second improvement is metric – 1-18.1;

patients that report using at least one self- management goal regularly will increase in DY5 by 10% over a baseline established in DY3.

Category 3 Outcomes: IT.~~6.1, our goal is to increase patient satisfaction scores (CG-CAHPS) as an indicator of health status and function~~10.1 Quality of Life/Functional Status is the selected stand alone metric for this project; a baseline will be established in DY3 with an expected improvement of X% (TBD) in DY4 and by X% (TBD) in DY5 compared with the baseline.

Project Narrative

Project Description: Currently, there is no prevention or cure for asthma. Children with asthma who do not have access to routine health care often miss school days due to their illness. Routinely, they access the emergency room for treatment which is the most expensive setting for care. A study by the Agency for Healthcare Research and Quality found significant disparities in asthma status and home management practices across racial/ethnic lines. African-American children with similar insurance and socio-demographic status have more severe asthma than white children based on the number of symptom days, school days missed, and health status scores. Additionally, African-American children are about three times more likely to be admitted to a hospital for asthma than white children. (Stanton 2005)

Through this demonstration project managed by the academic faculty of UTHSCT and facilitated by staff with the Northeast Texas Center for Rural Community Health (NET-RCH), two mobile, multi-disciplinary teams will be hired, trained, and deployed under the supervision of an Immunology/Allergy expert for pediatric populations to create access for definitive diagnosis, treatment education, and disease self-management support. Each team will provide services to two geographically distinct areas of RHP Region 1.

Between 1980 and 1994, the prevalence of asthma in the U.S. increased 75% overall, and 74% among children 5 to 14 years of age, making childhood asthma an important public health concern. In 2002, asthma treatment costs in the United States were $12 billion, and the estimated cost of treating asthma for those younger than 18 years of age was $6 billion per year. (Wise, 2004) In TX HHSC 1115 Waiver Region 1, asthma outcomes from 2000 – 2003 indicate that the hospitalization rate is 13/10,000 as compared to the state hospitalization rate of 11.48/10,000. The rate for African-Americans is 18.65/10,000. (Harrison 2011) Children and adolescents who have asthma can still maintain quality, productive lives if they control their asthma through medication and avoid contact with environmental "triggers" for acute episodes which include cockroaches, dust mites, furry pets, mold, tobacco smoke, and certain chemicals.

The **goal** of this project is to implement a collaborative program of chronic disease management for children who have serious respiratory problems (asthma/allergies) in order to improve access to care and to potentially prevent hospitalizations. This project will address unmet needs of residents in at least twelve counties in the region served by CHRISTUS St. Michael's in Texarkana and the UTHSCT- UPA clinics and regional goals of improving access to care, improving quality of care and patient satisfaction, and reducing the cost of healthcare.

Challenges to achieving the goal of the project include the potential delay in identifying, hiring and training personnel to staff the mobile units to achieve the ambitious schedule, securing full school district support for assistance with individual scheduling and helping students keep their

appointments; difficulties for parents to arrange their schedules in order to be present with the student for the appointment. The pilot program achieved success in overcoming these potential setbacks; the project manager and nursing staff will work with a project stakeholder advisory group in the Texarkana area and communities around northern Smith County to guide community-based engagement.

The **expected outcome** of this project in DY5 is that there will be a significant increase in the number of children diagnosed with asthma who understand their triggers, who know and practice disease self-management thereby enjoying an enhanced quality of life. It is expected that there will be a decrease ED visits and hospitalizations for acute asthma episodes.

Starting Point/Baseline: Currently neither health care organization is delivering pediatric respiratory services at remote locations. Previous evidence from a pilot program indicates the likelihood that a significant improvement in avoidable ED visits and hospitalizations can be accomplished for pediatric asthma when access to care, treatment education, and self-management instruction is provided. A pilot program conducted by the Immunology/Allergy clinic of the University of Texas Health Science Center during the 2008-09 school year used a Pediatric Mobile Asthma Unit roughly one day per week in cooperation with two Independent School Systems (five schools) in the Tyler area. In that time, the team diagnosed and followed 144 children with asthma and/or allergy induced breathing problems. Of the children screened, 75% had government issued or no insurance. The students were African American – 43%, Hispanic – 29%, and Caucasian 25%. The majority of patients experienced improved asthma control, a decrease in missed school days, reduced ED visits and fewer oral steroid bursts. No hospitalizations for asthma symptoms occurred during the pilot study. (Sharkey, 2010) These patients did not receive coaching after or between visits.

During the 12 month period of January 2011 through December 2011~~2~~ CHRISTUS St. Michael's experienced 308 ED visits for pediatric patients for treatment of asthma and hospitalization for 82 patients; the pay source for the vast majority was Medicaid or CHIP. The baseline for the population to be reached by the mobile teams will be established early in DY 2 based on clinic visits, ED visits and hospitalizations with consideration that mobile teams will greatly enhance the number of children as yet undiagnosed.

It is anticipated that start-up including hiring and training staff and deploying the mobile teams to establish baseline data for both service areas will be completed in DY3.

Rationale: RHP region 1 is rural, racially diverse, poor, and underserved by both primary health care providers and specialists. For the proposed 12 counties to be included in this project, all but two are designated by U.S. DHHS as Medically Underserved Areas, 38% of the percent of the population is rural, about 25% are under the age of 18, and nearly one-third of those children are living in poverty. (Texas DSHS, 2007)

The UTHSCT is a leader in lung disease and lung injury research. The physician specialists associated with the organization have established a long history of excellence in the treatment of pulmonary diseases among all age groups. This includes a physician board certified in Immunology and Allergies with significant experience treating pediatric asthma. Since 1985 the UTHSCT and the Texas Chest Foundation have sponsored a week-long camp each summer, *Texas Asthma Camp for Kids*, for about 75 children and adolescents. The camp staffed by

volunteers, engages youngsters with asthma in a variety of physical and educational activities in order to teach them to recognize physiological responses and engage appropriate self-management strategies in order to avoid an acute episode. There are always more children eligible to attend the camp than can be accommodated. The expertise to successfully conduct this project exists although it is not currently delivered to reach the underserved population.

CHRISTUS St. Michael's, a 312 bed hospital based in Texarkana, TX is collaborating on this innovative demonstration project to reach youth in their service area over a hundred miles from the UTHSCT campus, in order to reduce ED visits and hospitalizations for acute asthma episodes among their pediatric population. The mobile unit serving the UPA clinics will provide access to underserved children and facilitate establishing a medical home for them.

This highly collaborative project is undertaken in response to community needs identified in the RHP plan for Region 1: **CN.1** Insufficient access to primary & specialty services, **CN.3** high rates of chronic disease, including asthma, **CN.4** high costs due to potentially preventable hospitalizations, **CN.5** Inappropriate emergency department utilization.

To organize the focus and metrics for this **new initiative** , **Project Option 2.2** Expand Chronic Care Management Models was selected as the best match for the proposed scope of work and outcomes to demonstrate a transformation in delivery of care to individuals who have been diagnosed with a chronic disease. In this case, the chronic disease being addressed is pediatric asthma. Effective diagnosis and self-management will enable children to enjoy a rich quality of life. The Planned Care model (Stanton 2005) has been demonstrated to be an effective design to guide team care, support patient self-management and provide data points for easy incorporation into registries or electronic health records. (Coleman, 2012) The project includes the **required core components** as follows:

a) Two multidisciplinary teams will be hired, trained and deployed systematically in rural communities within service areas of two collaborating hospitals. Each team will operate under the supervision of a University Physician Associates (UPA) faculty member, board certified in Allergies and Immunology who also has expertise in the treatment of pediatric asthma. Each team will include a Nurse Practitioner/Advanced Practice Professional, Nurse, 2 Community Health Workers (asthma management coaches), and Patient Representative. Using a staged implementation approach, each team will be hired and work initially with the physician specialist to develop/adapt clinical protocols using best practices including the Planned Care Model based on the Wagner Chronic Care Model (Wagner, 2011) as well as the Asthma APGAR tool. (Yawn, 2008) This strategy will facilitate relationship-building and trust among the team members.

Each of the two teams will provide services within their respective geographic areas through coordination with Independent School Districts. Schools have a vested interest in preventing student absenteeism for a number of reasons. Each team will work with the school nurse (through a school Cooperative for the smallest districts) and with the permission of appropriate school authorities. Each team will establish a schedule of screening locations to create access for currently underserved children. The team working with the UPA clinics on the UTHSCT campus will utilize a fully equipped 37-foot mobile unit as an asthma clinic while the CHRISTUS St. Michael's team will outfit an available 16-foot trailer with supplies and consultation area; they will actually utilize space on the school campus to set up for clinical services. It is anticipated that by DY4 each team will be deployed and average of ~~4~~ 3 days per week during

the school year and 2-3 days per week over the summer by participating in community health fairs.

b) Each team will follow the established protocols to determine a definitive diagnosis, treatment plan, referral to a medical home if needed, and follow-up by phone or in-home visits for high risk cases. The physician specialist will be available for phone consultation if needed. Specially trained Community Health Workers will provide follow-up by phone and social networking (as available) to reinforce disease self-management skills for the young patient and the family, facilitate enrollment with a primary care provider if needed, and assist with the identification of community resources necessary to maintain disease management. The CHW's will be equipped with smart phones and their protocol will include providing 24 hour contact information to everyone in their caseload. Project staff will meet monthly by phone or web-based meeting for case review, challenges, lessons learned, and opportunities.

c) To provide ongoing support for patients, team members will work with the school nurses, local physician's offices and community clinics to schedule community and patient education about asthma. Team members will provide phone and social network messaging support to patients throughout the year.

d) This project is **innovative** in that it provides trained personnel and access for underserved patients to learn about their chronic disease, for the patient and family to understand the disease process and the importance of adhering to proactive, self-management strategies that include using corticosteroids appropriately, and providing coaching and mentoring to help patients gain confidence in their ability to manage their chronic condition while enjoying an active lifestyle.

e) Regular team meetings will create a **learning collaborative** to benefit nearly half of the region (12 of 28 counties). Clinical experiences, case review, creative problem-solving, and rapid cycle PDSA will be incorporated into these meetings in order to assure continuous **quality improvement** and contribute to establishing best practices for this type of service delivery in a rural area. In addition, since one team is based at the region's academic health center, project results will be shared through The Northeast Texas Consortium and Center for Educational Technologies, a collaborative with 15 higher education institutions, 4 hospitals, and 26 school districts in the region. It is anticipated that project results will result in the production of a peer-reviewed manuscript and findings will also be reported at professional conferences.

Related Category 3 Outcome Measure(s): The selected Category 3 Outcome Measure for this project is from Outcome Domain ~~6~~ 10– ~~Patient Satisfaction~~ Quality of Life; IT-~~6~~ 10.1. This metric was selected because although the proposed delivery model will transform the system to provide services by the right staff, in the right place ultimately reducing ED visits and hospitalizations for pediatric asthma, the hospital-based metrics alone will not adequately capture the positive outcome of the system re-design. Further, the focus of this project is on increased access with proactive education and follow-up to support patient self-management of a chronic condition. There is evidence to suggest that patient compliance is influenced by the effective use of information systems and self-management support services. Compliance is also tied to the patient's perception that their needs are met, that they have access to the appropriate provider when needed, and that their self-management program is supported. (Malouin 2010) We will administer the ~~CAHPS Child Primary Care Questionnaire 2.0~~ PedsQL as

the outcome improvement metric for this project. ~~This version of the standardized survey takes an objective approach to assess patient's perceptions of consistency of actions performed in three domains including office (in this case mobile unit) staff helpfulness, doctor-patient communication, and timeliness of care. The survey uses a 4-point scale that will facilitate administration and comprehension by the target population for these services. Although the survey was designed to be administered in the context of the Family-Centered Medical Home,~~ We believe it is valid for this population for the following reasons: 1) it is one of the few standardized, validated survey tools for pediatric patients/services, 2) ~~if children who receive care from a mobile asthma team do not have an established primary care provider a referral will be facilitated, the team will make the primary care provider aware of the respiratory treatment plan~~ it is practical, flexible and developmentally appropriate, 3) the CHW will function as a coach to help the child and family implement disease management strategies, 4) this ~~version of CAHPS-CG survey is being used by other states to evaluate their Medicaid program.~~ standardized 23 item tool measures core dimensions of health as well as school functioning thereby providing objective information to reinforce support from schools and parents.

Relationship to other Projects:
127278302.1.4 will train Community Health Workers for certification and deployment as members of the chronic care teams. The ongoing assessment of the training program will include feedback from CHW's who are working in various DSRIP projects throughout the region. In addition, candidates will be selected to receive additional training to achieve competence as pediatric asthma coaches. Both NET-CRCH and CHRISTUS will work with the Department of Labor to become certified CHW apprenticeship locations in order to provide additional mentoring for workers assigned to the mobile asthma unit teams. Those involved with the apprenticeship program will also participate in one annual meeting to share lessons learned, challenges, and gaps in training or practical experience.

The project will also have implications for **Category 4** measures such as patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.

Relationship to Other Performing Providers' Projects in the RHP: Successes and lessons learned will be shared by other RHP members through the regional learning collaborative described below.

Plan for Learning Collaborative: The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health (The Center). The Center was established for the purpose of: 1) engaging in community health service activities within the Northeast Texas region and 2) enhancing, promoting, coordinating, and supporting faculty and student projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. The Center will: 1) convene internal and external stakeholders to participate in sharing challenges and lessons learned; 2) facilitate Regional Health Plan meetings and communicate Regional Health Plan

purpose and progress; 3) assist with identification of community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project; 4) coordinate efforts among the Regional Health Partnership including facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence; 5) monitoring outputs, metrics, and intermediate outcomes, coordinating data, and reporting on the progress of the Regional Health Plan; 6.) serve as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: The valuation of this transformative project is justified as follows:

- Providing care for undiagnosed and/or underserved, children in poverty in twelve rural counties will reduce actual health care system costs Dougherty (2005).
- the long term cost savings to the Medicaid system by the early detection, treatment and self-management skills that will be delivered, thereby reducing life-long care costs
- improved quality of life through effective chronic disease management will allow a significant segment of the population to engage in productive lifestyles in adulthood
- A vast geographic area of the region is addressed by the project
- A significant number of partners will make implementation feasible, successful, and sustainable. In addition to the collaborating hospitals, relationships will be enhanced with Independent school systems through school nurses or School Health Advisory Committees (SHACS) to reach children through their routine schedule. School systems have a vested interest in reducing absenteeism, especially through preventable illnesses.

References:

CAHPS®. *CAHPS Child Survey: Questions for Children with Chronic Conditions.* Rockville, MD: Agency for Healthcare Research and Quality; 2006.

Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the chronic care model in the new millennium. Health Affairs, 2009 2(1):75-85.

Harrison W. Asthma morbidity and mortality in Texas. 2011 www.dshs.state.**tx**.us/WorkArea/linkit (last accessed 10-17-12)

Malouin Rebecca, Merten S, (2010) Tools to Evaluate the Pediatric Patient-and Family Centered Medical Home, American Academy of Pediatrics' National Center for Medical Home Implementation; US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau

Owens PL, Thompson J, Elixhauser A et.al., Care of children and adolescents in U.S. Hospitals. Rockville(MD): Agency for Healthcare Research and Quality; 2003. HCUP Fact Book No. R. AHRQ Pub. No. 04-0004

Stanton MW, Dougherty D. Chronic Care for low-income children with asthma: strategies for improvement. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 18. AHRQ Pub. No. 05-0073

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10/10/2012).

Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi, A. Improving chronic care: translating evidence into action. Health Aff Nov 2001 vol. 20 (5):64-78.

Wise PH (2004) The transformation of child health in the United State. Health Affairs 23(5):9-25.

Yawn BP, Bertram S, Wollan P. Introduction of asthma APGAR tools improve asthma management in primary care practices. J Asthma Allergy 2008 Aug 31; 1:1-10.

127278302.2.16 Pass 3b (127278302.2.4 (Pass 1)	2.2.1	2.2.1 A-E	Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – (Pediatric Asthma)	
UNIVERSITY PHYSICIAN ASSOCIATES				127278302
Related Category 3 Outcome Measure(s):	127278302.3.45 Pass 3b (127278302.3.19)	3.IT-~~6.1~~10.1	~~Patient Satisfaction – percent improvement over baseline of patient satisfaction scores~~ Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-3: Develop a comprehensive care management program Metric 1 P-3.1: Documentation of Care Management Program Baseline/Goal: Hire project team to develop Best Practices plan including Planned Care Model and Asthma APGAR Data Source: Program Materials Milestone 1 Estimated Incentive Payment : $1,270,750	**Milestone 2** P-2: Train staff in the Chronic Care Model Metric 1 P-2.1: Increase percent of staff trained Baseline/Goal: 100% of relevant staff will complete the PCM training and mobile team operation protocols Data Source: training report materials Milestone 2 Estimated Incentive Payment: $1,230,735 **Milestone 3** P-11: Develop and implement program to assist patient & family to better self-manage their asthma Metric 1 P-11.1: Increase the number of patients enrolled in a self-management program Baseline/Goal: establish baseline for patients enrolled in self-management program through mobile team encounter Data Source: Patient registry and medical records Milestone 3 Estimated Incentive Payment: $1,230,735		**Milestone 4** P-16: Participate in face-to face learning Metric 1 P-16.1: Participate in semi-annual face-to-face meetings/seminar organized by the RHP Goal: participation as organized by the RHP Data Source: Meeting presentations & notes Milestone 4 Estimated Incentive Payment: $1,520,488 **Milestone 5** I-21: Improvements in access to care Metric 1 I-21.2: Increase number of unique patients served by this innovative program Goal: Increase by 5% over baseline Data Source: Patient registry and medical records Milestone 5 Estimated Incentive Payment: $1,520,488	**Milestone 6** I-21: Improvements in access to care Metric 1 I-21.2: Increase number of unique patients served by this innovative program Goal: Increase number of unique patients seen by 10% over baseline Data Source: Patient registry, medical records Milestone 6 Estimated Incentive Payment: $1,289,838 **Milestone 7** I-18.1: Improve percentage of patients with self-management goals Metric 1 I-18.1: Patients with self-management goals Goal: 10% of patients enrolled through the mobile team will report using at least one self-management goal regularly Data Source: Patient medical record, CHW documentation Milestone 7 Estimated Incentive Payment: $1,289,838 Estimate of number of patients served over the course of the project is 1500, with an average volume of services 2 per child.

127278302.2.16 Pass 3b (127278302.2.4 (Pass 1)	2.2.1	2.2.1 A-E	Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – (Pediatric Asthma)	
UNIVERSITY PHYSICIAN ASSOCIATES				127278302
Related Category 3 Outcome Measure(s):	127278302.3.45 Pass 3b (127278302.3.19)	3.IT-~~6.1~~10.1	~~Patient Satisfaction – percent improvement over baseline of patient satisfaction scores~~ Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $1,270,750		Year 3 Estimated Milestone Bundle Amount: $2,461,470	Year 4 Estimated Milestone Bundle Amount: $3,040,976	Year 5 Estimated Milestone Bundle Amount: 2,579,676
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $9,352,872				

Project Option 2.7.1 - Implement innovative evidence-based strategies to increase appropriate use of technology and testing or targeted populations (Colonoscopy)
Unique Project Identification Number: 127278302.2.5 (Pass 1)
Performing Provider/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center (UTHSCT) is comprised of a 109 bed acute teaching hospital, three medical residency programs, primary and specialty care clinics, and a state of the art cancer detection and treatment center inaugurated in 2011. The academic medical center is located in the northeast corner of Smith County and serves a population of primarily rural residents. The hospital campus is located in the extreme northeast corner of Smith County and draws patients from within a 50 mile radius encompassing seven counties. The University Physician Associates (UPA) is comprised of the physician faculty for the institution.

Intervention: To carry out this new initiative, a team will be formed to simultaneously increase access to specialty providers for GI, medical oncology, and surgical oncology while launching an aggressive social marketing campaign increase colorectal screening among target populations that experience health disparities. Texas DSHS certified CHWs who are representative of the target population will implement the outreach program to educate and support patient utilization of colon cancer screening procedures. The CHWs will also serve as patient navigators for patients requiring further diagnostic/treatment services.

Need for Project: It is estimated that at least 50% of colorectal cancer deaths could be prevented if individuals aged of 50 and older were regularly screened. No educational outreach program is currently in place to reach this population or specifically underserved minority residents. The current medical team (1 GI, 1 Nurse Practitioner, 2 medical oncologists and 1 FNP) performed 500 colonoscopies during the 12 month period ending in June 2012 within the full range of services they provide.

Target Population: Rural residents of the seven county service area surrounding the UTHSCT number 55,000 over the age of 65; about 10% are African American and 11% Hispanic. This population as a whole is poor, has limited health literacy, and lacks access/utilization of routine preventive health care. 54% of the patients who use UTHSCT outpatient services are Medicaid and self-pay.

Category 2 Expected Patient Benefits: The project seeks to provide colonoscopy screening and secondary prevention services to an underserved population of ~~X% (TBD)~~ 5% over baseline in DY 4 and 10% in DY5 compared to the baseline established in DY2. This project is expected to cover a base patient population of 1,600 with unique colonoscopy screening services not readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, up to 1,200 patients/clients will receive or be engaged in colorectal cancer screening outreach activities by DY 5, who did not previously have direct access to such activities. The improvement milestone for this project to increase number of colonoscopy encounters for early cancer detection directly reflects the quantitative impact of the project on the population served.

Category 3 Outcomes: The lack of knowledge about the high rates of colorectal cancer in the region and understanding cultural and ethnic resistance to participating in colorectal screening, the effectiveness of the social marketing campaign is essential to success. Therefore, IT-6.1 Patient Satisfaction measured by CG-CAHPS is the selected improvement metric. Our goal is to improve patient satisfaction with the screening and treatment experience by X% (TBD) in both DY4 and DY5 compared to the baseline established in DY2.

PDSA cycles will be implemented initially in DY3 and throughout the project duration to improve data collection and intervention activities.

Project Narrative

Project Description: Early colon cancer screening methods reduce mortality and can decrease incidence through the removal of precancerous lesions (Pignone, 2002). The 5-year survival rate is 90% for localized-stage disease; those rates drop to 68% and 11% for patients diagnosed with cancer sites at the regional and distant stage, respectively (ACS, 2008). The current American Cancer Society guidelines on screening and surveillance for the early detection of colorectal cancer recommend that people who have no identified risk factors should begin regular screening at age 50. Individuals with increased risk such as those with family history or a history of polyps on prior colonoscopy should consult with a physician about recommended screening options before age 50. Additionally, due to increased incidence in this population, the American College of Gastroenterology recently recommended that screening of African Americans begin at age 45 (Coughlin, 2006).

Important initial work has been done to understand the cultural and social beliefs and other considerations that deter African-Americans and Hispanics in particular from being screened for colon cancer. (Puschel, et.al 2010, Coughlin, et.al, 2006, Seef, et. al, 2003, Ward, et.al 2004) Among other issues, these authors note cultural belief barriers such a *machismo* for Hispanic men, fatalism, cancer as a punishment from God, and the feeling that they would "rather not know". Ward, et.al indicated that for African-Americans, in addition to structural barriers (finances, distance to treatment center, and transportation), physician recommendations contribute to patient action. In fact, a report from the Institute of Medicine (Nelson, et.al 2002) concluded that "bias, stereotyping, prejudice and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care." In response to what is currently understood about cultural and socioeconomic barriers that contribute to the low rates of primary and secondary colon cancer screening, an innovative and ambitious **educational campaign** based on social marketing principles (Kotler, et.al,2002) will be designed and launched to increase the number of HHSC RHP 1 residents who have a colon cancer screening exam. This service redesign project will develop, implement and continually assess targeted educational and outreach activities created to change perceptions about the importance, accessibility, and acceptability of colon cancer screening for two target audiences. One targeted audience is the primary care providers who staff UPA clinics and the seven counties that surround the UTHSCT. In order to change knowledge, address barriers and improve utilization behaviors for the targeted patient populations, community advisory groups will be formed to assist with the development of social marketing messages designed to address the beliefs and attitudes of their community. Community Health Workers (CHWs) will play an instrumental role as project team members who assist with developing and disseminating the social marketing program, provide

patient support navigating treatment as needed, and keeping the team informed of community attitudes, concerns and adoption of practices promoted by the program.

The overall **goal** of this project is to reduce health disparities and increase the number of un-served adults who receive colon cancer screening according to accepted ACS guidelines.

Challenges to the implementation of this project center around overcoming cultural barriers and social taboos related to colon cancer screening. The community advisory groups will guide the social marketing campaign to address those barriers with a meaningful message(s) to encourage behavior change. Given the current rates of cancer, low participation in screening, and resistance to screening, it is anticipated that the initial success of the program will identify patients who require secondary prevention and early treatment. Another **challenge** relates to changing the perceptions of primary care providers about the importance of educating patients, making referrals for screening, and providing a follow-up reminder to the patient. This will be addressed through formal and informal CME activities (see learning collaborative description), improving the effectiveness of referral and follow-up processes to assure timely appointments and a feedback loop to the referring clinician.

The **expected outcome** at the conclusion of this project in DY5 is that primary care providers will be proactive in referral and follow-up for colon cancer screening per current guidelines for their patients. Also, members of the target populations will understand the importance of colon cancer screening and act on this knowledge. This will lead to an increase in the number of screenings performed as well as secondary prevention and treatment procedures to reduce mortality among the target population. Early treatment will both improve the quality of life and reduce care costs.

Starting Point/Baseline: The University Physician Associate primary care clinicians have access to specialists (a gastroenterologist and NP, two medical oncologists and FNP, as well as surgeons) who perform screenings and treatment in a state of the art (2011) cancer treatment center on the campus of the University of Texas Health Science Center at Tyler. For the period July 2011 through June 2012 500 procedures for colon cancer screening, biopsy, and lesion removal were administered. The target population for this project includes the rural residents of seven counties that surround the UTHSCT (Anderson, Cherokee, Henderson, Smith, Rusk, Van Zandt, and Wood). Collectively, more than 55,000 residents are over age 65; slightly more than 10% of the total population is African American; Hispanics represent about 11% of the total. DY2 and DY3 will be dedicated to creating and deploying the social marketing campaign to increase demand for preventive screening procedures.

Rationale: Colorectal cancer is the third most commonly diagnosed cancer and the third leading cause of cancer death in both men and women in the United States. For reasons that are not clear, Northeast Texas residents experience rates of colorectal cancer higher than the state rate of Texas. An increased colorectal cancer incidence rate of 47.6% for HHSC RHP 1 compared to the statewide rate of 44.2% presents an imperative to expand early cancer detection programs. A similar trend exists for cancer mortality rates; the overall colorectal cancer mortality rate for HHSC RHP 1 is 17.8% and the statewide rate is 16.2% (TCR). This project is designed to meet **Community Need (CN.3),** high rates of chronic disease, including asthma, obesity, and cancer.

Early colon cancer detection screening options include flexible sigmoidoscopy, colonoscopy, double-contrast barium enema, CT colonography, and fecal occult blood test. This project will focus on secondary prevention efforts for patients and individuals who are at an increased risk for

developing colon cancer. Colonoscopy is the recommended screening method for this population (ACS, 2011).

It is estimated that between 50 and 60% of colorectal cancer deaths could be avoided if all individuals aged 50 and older had regular screening tests. Despite their effectiveness in reducing colorectal cancer incidence and mortality, there is widespread underutilization of screening and treatment among the US populations, more so among minority groups. In 2000, fewer than half (42%) of US age-eligible adults reported receiving any screening tests (Seeff, 2004) and for the state of Texas, 38.5% of adults aged 50 and older reported they have never had a sigmoidoscopy or colonoscopy per the 2010 Texas Department of State Health Services Behavioral Risk Factor Surveillance System results. Barriers to screening utilization are numerous. Strongly correlated factors to inadequate screening are cost and lack of access to health care, in addition to lack of knowledge, lack of physician recommendation, and embarrassment and fear (ACS, 2011; Seeff, 2004; Stanley, 2012).

The emphasis and success of this program is tied to effective, innovative social marketing strategies guided by community members and implemented by the CHWs and community opinion leaders. These efforts will be concentrated in Anderson, Cherokee, Henderson, Rusk, Smith, Van Zandt, and Wood counties. Three individuals who have completed the CHW training program, achieved certification and are representative of the targeted population(s) will be hired exclusively for this project. Community advisory groups will be engaged, comprised of trusted entities and recognized opinion leaders within the community. They will work with a social marketing consultant to guide the development and dissemination of the public health message about colon cancer screening. The outreach program will utilize social support systems including faith-based organizations, local providers, community leaders and other relevant groups and individuals guided by recommendations from the community advisors. To capitalize on this opportunity to reach community members, CHWs in the outreach program will incorporate other health information such as nutrition, exercise and other public health practices that can be protective for the development of colon cancer, as well as to support improving the health status of this largely poor, underserved rural population.

The CHWs will serve as navigators for patients whose screening results indicate further diagnostic or treatment procedures. Current referral and follow-up mechanisms will be evaluated and enhanced as needed during the process of developing the implementation plan. Clinical champions for both primary and specialty care services, CHW, project manager, quality improvement and information technology staff will streamline processes to assure a satisfactory experience for the patient, minimize referral time to scheduling diagnostics/treatment, and provide a feedback loop for primary care providers to receive documentation of outcomes and recommendations. Another component of this project is team-based education and training for the primary and specialty care staff to improve appreciation for the importance of colon cancer screening referrals, barriers perceived by patients, and the important role that primary care providers play in motivating their patients to act on the recommendations. It is expected that the success of the targeted outreach and education program will create an increased demand for screening services generating findings that require secondary prevention and treatment measures. Starting in DY2 arrangements will be made to provide direct access for patients needing gastroenterology, medical oncology and surgical oncology services.

This **new initiative** will require hiring a dedicated project team and identifying clinical champions to participate in formal and informal peer education. A social marketing consultant will be identified to craft messages for the outreach program. Community advisory groups will be key to the formation of messages for African-American, Hispanic and rural white populations to address perceptions and barriers to colon cancer screening. The DY 2 process milestone (2.P-1) will assess the progress made on these activities. The project team will also review data from multiple sources in order to establish a baseline of current service utilization by target population and area of residence. This data will serve as the baseline for improvement milestones in DY 3-5. The DY 2 process milestone (2.P-2) to implement the plan will be measured based upon the training logs and documented processes and guidelines for integration with primary care physicians and staff. A gastroenterologist will be added to the UPA clinical team to assist with CME for primary care practitioners as well as the quality improvement processes related to referral and feedback loops.

The DY 3 process milestone (2.P-X) was selected in recognition of the importance of community and population outreach to positively impact the increase in colorectal cancer detection procedures. Three certified CHWs (127278302.1.4) will be actively implementing outreach and education activities using social marketing strategies to promote colon cancer screening for early detection and treatment with their target populations. Milestone achievement will be measured by project documentation. The DY 3 improvement milestone (2.I-5) will be to establish the number of patients in the target population who are receiving the intervention services that have been implemented including colorectal cancer screening methods, patient navigator services, and early treatment options. This milestone will be assessed using data from schedule and patient logs and navigator records on patients served. It is anticipated that arrangements will be made to increase the availability of a medical oncologist and surgical oncologist during DY3 in order to provide timely care for persons who have diagnostic procedures. Based on the regional data, it is anticipated that initial case finding may be at advanced stages requiring more advanced procedures and treatment.

The improvement milestone (2.I-7) for DY 4 will be to increase the access to colorectal screening encounters by ~~a percentage TBD~~ 5% over DY 3 numbers based upon the baseline data that is to be established in DY 2. Improvement milestone (2.I-X) will be to increase the community outreach and educational campaign to an expanded geographical region. A robust social marketing campaign geared to specific target audiences should generate greater interest and demand for screening procedures. Through a “lessons-learned” approach, the current outreach efforts will be examined and evaluated for effectiveness and success and these findings will be used to expand the target population as indicated.

DY 5 activities will continue to focus on the overall expected outcome of the project, increased access to colorectal cancer screening services in our target population area. The goal for Improvement Milestone (2.I-7) will be to further increase the number of colonoscopy encounters by ~~a percentage TBD~~ 10% ~~over DY 3 and 4 numbers based upon~~ baseline data that is to be established in DY 2. The percentage improvement will be evaluated and adjusted as necessary as the project progresses and processes are evaluated through team meeting results, from patient satisfaction surveys, and feedback from the community advisory groups.

Related Category 3 Outcome Measure(s): Quality improvement assessment will be ongoing with the project and clinical team using PDSA methods and, it is likely that active screening will result in potentially preventable admissions. However, given the importance of community outreach and

education, the result of this **new initiative** will be assessed using patient satisfaction (OD-6, IT-6.1). Through the use of Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) surveys, the impact of service expansion will be measured based upon key domains to be established in the patient satisfaction implementation plan (3.P-1). The rationale for choosing patient satisfaction as the related outcome domain is based on the ability of the CG-CAHPS survey to provide standardized data instruments for measuring and addressing patient experiences with providers and office staff (CAHPS). "The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers" (TX HHSC).

Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure, clinical, and educational expertise to benefit the following RHP project(s):

- 127278302.1.4: Increase Training of Primary Care Workforce; Capacity Building through Workforce Development: Training Community Health Workers
- 127278302.2.1: Enhance/Expand Medical Homes for UPA Primary Clinic - colorectal screening is one of the Cat 3 outcomes

This project could also have implications for **Category 4** measures such as patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.

Relationship to Other Performing Providers' Projects in the RHP: N/A

Plan for Learning Collaborative: The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health (The Center). The Center will serve as a convener of external and internal partners to share DSRIP project implementation and lessons learned. It will serve as the clearing house for best practices and regional data transmission through the process of implementation of DSRIP projects.

Project Valuation: Colorectal cancer is an important screening procedure that can decrease cancer incidence and reduce mortality. (Pignone, 2002) Early detection and treatment improves the quality of life, life expectancy and improves the health of populations. The use of social marketing messages designed for targeted minority populations **addresses regional goals** and will encourage appropriate utilization of the healthcare system. The value of this project exceeds the investment through educational efforts with both minority populations and primary care providers about the importance of screening, early detection, and treatment.

- Primary and secondary prevention and early treatment of colorectal cancers reduce long term cost savings to the healthcare.
- Rates for colon cancer in RHP 1 are higher than State of Texas rates.
- A community-based education and social marketing campaign will be designed to reach the population in at least one-third of the counties in the region with health promotion messages.
- Additional specialists who can screen for, stage and treat colon cancer will increase capacity to address this under recognized cancer and underutilized prevention measures.

- Primary care providers will be reminded of the importance of their referral for colon cancer screening as a function of influencing patient action.

References:

American Cancer Society, High Plains Division, INC. *Texas Facts & Figures 2008*. Austin, TX: American Cancer Society, High Plains Division, 2008.

American Cancer Society. *Colorectal Cancer Facts & Figures 2011-2013*. Atlanta: American Cancer Society, 2011.

Blumenthal DS, Smith SA, Majett CD & Alema-Mensah E. A trial of 3 intervention to promote colorectal cancer screening in African Americans. *Cancer*. 2010;116:922-9.

Coughlin SS, Costanza ME, Fernandez ME, et al. CDC-Funded intervention research aimed at promoting colorectal cancer screening in communities. *Cancer Supp*. 2006;107(5):1196-1204.

Kotler P, Roberto N, Lee N. Social marketing improving the quality of life. 2nd edition Sage Publications, CA 2002.

Nelson A. Unequal treatment: confronting racial and ethnic disparities in health care. 2002 J NMA Aug. vol. 94(8):666-668.

Pignone M, Rich M, Teutsch SM, et al. Screening for colorectal cancer in adults at average risk: a summary of the evidence for the U.S. preventive Services Task Force. *Ann Intern Med.* 2002; 137:132-141.

Puschel K, Thompson B, Coronado GD, Lopez LC, Kimball AM. Factors related to cancer screening in hispanics: a comparison of the perceptions of hispanic community members, health care providers, and representatives of organizations that serve Hispanics. Health Educ Baha 2001 28:573-590.

Seeff LC, Nadel MR, Klabunde CN, et al. Patterns and predictors of colorectal cancer test use in the adult U.S. population. *Cancer*. 2004;100:2093-103.

Stanley SL, King JB, Thomas CC, & Richardson LC. Factors associated with never being screened for colorectal cancer [published online ahead of print August 9, 2012]. *J Comm Health*. 2012. doi 10.1007/s10900-012-9600-x

Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry (TX DSHS). Data Request # 12202 8/13/2012 Incidence Source: Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry, Incidence - Texas, 1995-2009, Cut-off 11-23-11, SEER*Prep 2.4.5

Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry (TX DSHS). Data Request # 12202 8/13/2012 Mortality Source: Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry, Mortality - Texas, 1990-2009, SEERPop-Adj, SEER*Prep 2.4.5, (created 01/25/12).

Ward E, Jemal A, Cokkinides V, Sing GK, Cardinz D, Ghafoor A, Thun M. Cancer disparities by race/ethnicity and socioeconomic status. Cancer Journal for Clinicians March/April 2004 vol. 54(2).

127278302.2.5	2.7.1	2.7.1	IMPLEMENT EVIDENCE-BASED DISEASE PREVENTION PROGRAM – COLON CANCER	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	127278302.3.20	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Development of innovative evidence-based project for targeted population. Metric 1 P-1.1: Document innovational strategy and plan Baseline/Goal: Recruit and hire Project staff, form community advisory groups, begin social marketing plan Data Source: Documentation of team assignment, training logs and implementation plan Milestone 1 Estimated Incentive Payment (*maximum amount)*: $998,933 **Milestone 2** P-2: Implement evidence-based innovational project for targeted population Metric 1 P-2.1: Document implementation strategy and testing outcomes Baseline/Goal: Train primary care physicians and staff on improved referral and follow-up processes for patients participating in colon cancer screening Data Source: Documentation of training logs, processes and guidelines Milestone 2 Estimated Incentive Payment: $998,933		**Milestone 3** P-X: Develop and implement community outreach and educational campaign for targeted population Metric 1 P-X.1: Document community outreach strategy Baseline/Goal: Hire and train CHWs (3) to develop and implement educational campaign to increase screening population Data Source: Documentation of team assignment, training logs, and outreach events Milestone 3 Estimated Incentive Payment: ~~$1,107,690~~ $1,246,151.50 **Milestone 4** I-5: Identify X number of patients in a defined population receiving innovative intervention consistent with evidence-based model Metric 1 [I-5.1]: Document number of individuals utilizing UPA colorectal cancer screening and early treatment option services Goal: TBD based upon baseline data established in DY2 Data Source: Documentation of schedule and patient logs Milestone 4 Estimated Incentive Payment: ~~$1,107,690~~ $1,246,151.50	**Milestone 5** I-7: Increase access to disease prevention programs using innovative project option. Metric 1 I-7.2: Increase number of colonoscopy encounters for early cancer detection Goal: Increase number of encounters by ~~percent TBD over DY3~~ 5% over baseline Data Source: Documentation of schedule and patient logs Milestone 5 Estimated Incentive Payment: ~~$1,138,764~~ $1,209,937 **Milestone 6** I-X: Increase community outreach and educational campaign to expanded geographical area Metric 1 I-X.1: Increased educational outreach area Goal: Expand geographical boundaries originally established in DY3 Data Source: Documentation of contact lists and outreach events Milestone 6 Estimated Incentive Payment: ~~$1,138,764~~ $1,209,937	**Milestone 7** I-7: Increase access to disease prevention programs using innovative project option. Metric 1 I-7.2: Increase number of colonoscopy encounters for early cancer detection Goal: Increase number of encounters by ~~percent TBD over DY3~~ 10% over baseline Data Source: Documentation of schedule and patient logs Milestone 7 Estimated Incentive Payment: ~~$1,974,821~~ $2,259,939 Estimated population to be engaged in community outreach events through DY 5: 1,200 Estimated number of colonoscopy encounters for existing and new targeted population through DY 5: 1,600

Year 2 Estimated Milestone Bundle Amount: $1,997,866	Year 3 Estimated Milestone Bundle Amount: ~~$ 2,215,380~~ $2,492,303	Year 4 Estimated Milestone Bundle Amount: ~~$ 2,277,528~~ $2,419,874	Year 5 Estimated Milestone Bundle Amount: ~~$1,974,821~~ $2,256,939
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:** ~~$ 8,465,595~~ $9,166,982			

Project Option: 2.8.4 – Apply Process Improvement Methodology to Improve Quality/Efficiency
Unique Project Identification Number: 127278302.2.17 Pass 3b (127278302.2.6) (PASS 1)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler, the only academic medical center in Region 1, is comprised of a 109 bed acute care hospital with residency training programs in family, occupational and internal medicine. Organizationally, medical faculty functions as the University Physician Associates (UPA). Good Shepherd Medical Center, Longview – a 435 bed acute care facility, CHRISTUS St. Michael's a 312 bed acute care hospital, Palestine Regional Medical Center is an acute care hospital with 150 beds and the UTHSCT will collaborate on this new initiative.

Intervention: Four hospital systems will participate in learning collaboratively to acquire knowledge about and practical experience with a variety of quality improvement tools. Using reduction in 30 day readmissions for CHF as a target, the teams will participate in didactic sessions, root cause analysis, QI tool selection and application to a process point along the continuum of prevention of CHF readmission. Regularly scheduled meetings and site visits will enable all teams to benefit from the experience and lessons learned by other LCT teams to move all towards a culture of quality within their own institutions.

Need for the Project: Each of the hospitals involved in this project recognizes the need to redesign their systems and procedures to improve the quality and efficiency of operations. **Small hospitals in rural areas are challenged by a lack of resources to select and systematically implement QI activities throughout the entire operation**. The incidence rate of CHF in Region 1 exceeds the state rate, therefore this project addresses **CN. 3** high rates of chronic disease and **CN.6** Efficiency and effectiveness of health care delivery.

Category 2 Expected Patient Benefits: The project seeks to establish a culture of quality supported by acquired skills in a variety of QI tools. Achievement will be measured by the increase in designated quality champions in each hospital by 10% in DY 4 over the baseline established in DY2 and by 10% over DY4 achievement in DY5. The required estimate of number of patients served and volume of services is predicated on the Category 3 metric to decrease CHF readmissions as a tangible, measurable target. However, the focus of this project is to foster a culture of quality & safety as outlined in the PFM menu, the project impact will be more far-reaching and as yet inestimable. Over the demonstration project period, this project intends to reach 600 CHF patients with an equal volume of services. Given the poverty rates in the service area for the partner hospitals, it is anticipated that 40% of the patient mix is Medicaid eligible or indigent.

Category 3 Outcomes: IT-3.2 each hospital will achieve a reduction in 30 day readmissions for CHF in DY4 by X% TBD over the baseline determined after review of hospital utilization records in DY3. The reduction in DY5 will be X% TBD over the baseline established in DY3.

Project Narrative

Project Description: This project will establish a Learning Collaborative among four organizations (five hospitals) in HHSC Region 1 for the purpose of advancing the knowledge, practice and science of Quality Improvement/Efficiency. This will be accomplished by working jointly to address the continuum of care for Congestive Heart Failure (CHF) patients; identifying and adopting "best practices" to reduce potentially preventable admissions and readmissions, reduce costs, and improve the quality and efficiency of care. The project will be facilitated by the Northeast Center for Rural Community Health (NET-CRCH) with faculty leadership from the academic medical center University Physician Associates (UPA). The four hospital partners include the University of Texas Health Science Center at Tyler (UTHSCT), Good Shepherd Medical Center in Longview (GSMC-L), Good Shepherd Medical Center – Marshall, (GSMC-M), CHRISTUS St Michael's (CSM) in Texarkana, and Palestine Regional Medical Center (PRMC) Palestine. With full administrative engagement, each partnering institution will identify a Learning Collaborative Transformation (LCT) team whose members include a physician champion, administration champion, cardiology service representative, quality improvement staff, and information technology; others may be added as desired. The project will transform the capacity of each institution to systematically approach operational improvements; by providing leaders the opportunity to gain practical experience with a variety of QI tools. As the institutional leadership teams gain familiarity with a variety of quality improvement tools such as Lean- Six Sigma, Assessment of Chronic Illness Care, PDSA, the IHI- Framework for Execution, etc. (West, Oujiri, Bonomi, Lang, Shortell,) either directly or through experiences shared by colleagues, they will be prepared to select the appropriate tools given their improvement targets, resident expertise, and resources. The Learning Collaborative framework will provide the forum to share challenges and successes with peers from other institutions, and determine best practices in a collegial, supportive environment. As a result, the culture of safety, quality and efficiency will evolve and continue to improve in the partner institutions and serve as a model for other health care organizations in the region.

GSMC-L is a licensed 425-bed regional referral center; GSMC-M is staff for 141 beds; CHRISTUS St. Michaels is a licensed 312 bed acute care hospital; Palestine Regional Medical Center has 150 acute beds; and the UTHSCT is a 125 bed teaching hospital. Each entity provides a range of cardiology services. Each institution in the Learning Collaborative has identified that their current processes related to the management of CHF patients can be improved. With the Northeast Texas Center for Rural Community Health, (NET-CRCH) as the convener of this project, the workgroup will be guided through a systematic approach that is guided by the ten step process outlined for the learning collaborative model.

The goal of this project is to educate about and propagate effective QI/E strategies to improve the culture of quality, safety, and efficiency through a collaborative process between five

hospitals. The shared quality improvement task will focus on the continuum of care for CHF patient management that reduces preventable admissions, readmissions, reduces costs, and improves the quality of care.

There are challenges to accomplishing the goal for this project. The administration of each institution has committed to participate; however, it is possible that over the course of the demonstration period, institutional leadership could change. This risk will be mediated by establishing the inter-disciplinary LCT team very early in the process with a face-to-face team building session scheduled in the initial planning phase. As data sources and current processes are examined, there may be challenges with formulating standardized elements, system incompatibilities, and divergent processes that to deter developing "best practices". Additional challenges might include common development of specific policies and procedures, medical record documentation, identification of and training for specialty providers. The project facilitator will guide discussions relying on evidence-based tools to bring the group to consensus. Other challenges include limited personnel and other resources in smaller rural facilities, incomplete electronic health records implementation, and inability to integrate data collection systems which are required for the collection of metrics in any QI projects. The project will address these challenges by assessing these issues early and developing a plan to address them.

Starting Point/Baseline: QI/E Experience -The NET-CRCH recently added a staff member who has achieved the requirements for a "Mayo Clinic Silver Medal in Quality; he will serve as the project facilitator. While with the Mayo Clinic - Center for Innovations, he was the project manager for a transformative project which applied Lean for care for the institution's network hospitals. NET-CRH will also include the residency Program Directors for Family Medicine and Internal Medicine to assure include training about quality improvement strategies in the academic program.
The UTHSCT received a grant from the UT System in the summer of 2012 to support Lean training for designated teams; the training will be fully implemented in DY2. The institution has a very active and accomplished Quality Improvement team that has systematically implemented improvements in clinical processes. The QI team is currently developing measures that will be incorporated into the Family Medicine clinic as it moves toward Patient Centered Medical Home accreditation.
GSMC recently added a process engineer to its staff to guide QI initiatives and assist with evaluating the IT needs associated with QI projects. The nursing department is currently applying PDSA to an inpatient care issue. The Good Shepherd Medical Center-Marshall will also participate in this Learning Collaborative. CHRISTUS St. Michael's has an active Quality Improvement team that is currently focused on clinical nursing processes. Palestine Regional Medical Center has an active Quality Improvement team that is currently applying Lean analysis to ED processes.

Project implementation for DY2 and DY3 will focus primarily on assembling the LCT team through a series of in-person and web-based meetings. Quality Improvement principles will be reviewed so that everyone is conversant with the terminology and process philosophy. The

group will jointly develop an implementation plan, identify training needs for both the LCT members and within each institution, and establish project-level goals and outcomes that each will implement and report back to the group. The teams will discuss and determine the baseline metric for CHF 30 admissions and the target improvement measure to the attained by DY5.

The **expected outcome** by the conclusion of the project in DY5 will be an improved culture of safety, quality, and efficiency as demonstrated by the number of QI champions, processes reviewed and re-designed, and improved care for CHF patients that reduces re-admissions within 30 days. This will also result in performance achievement of a Category 3 intervention target intended to optimize the right care for the right setting, by the right provider. The secondary outcome of this project is the increased capacity and sustainability within the four participating health care providers to evaluate additional services/care models and implement innovative redesigned interventions that are piloted, tested, revised as indicated and implemented as new operational standards.

Rationale: Northeast Texas is a primarily rural area of the state. In 2007, the Texas Department of State Health Services conducted an East Texas community health needs assessment (ETCHNA) to document the scale of the healthcare issues in the region. Findings of this assessment revealed higher rates of preventable hospitalizations compared with those statewide, along with higher rates of chronic disease prevalence, selective cancer incidence, disproportionate disease burden among vulnerable populations, and unmet behavioral and mental health care needs. (Texas DSHS, 2007) As the academic medical center for the region, the NET-CRCH of the University of Texas Health Science Center is positioned to support a regional learning collaborative to address a wide range of concerns for health care institutions, as well as clinical and administrative professionals who are challenged to provide services for poor, ethnically diverse populations who may not have easy access to services (lack of transportation, shortage of providers, etc.) and who have high rates of chronic disease often with co-morbidities.

The science of Quality Improvement for health care is evolving. Quality improvement is a process, constantly iterative as attempts are made to address complex interventions with a number of inter-related components. Currently QI efforts do not routinely articulate what mechanism enables the intervention to work; the specific audience for whom the intervention works, or under what circumstances does it work? (Davidoff) Therefore, the expected outcome of this project is a contribution by DY5, to the science of QI in health care settings by answering these questions systematically for the DY5 five hospitals that serve a rural and poor population in Region 1. The LCT teams will have developed, implemented, revised and achieved consensus on best practices for the management of CHF patients with a reduction in potentially avoidable admissions, re-admissions and complications. A secondary outcome of this project is to build capacity in each hospital to sustain an effective QI to evaluate future care models that are innovative and redesign processes to improve designated outcomes of improved health, reduced cost of care, and enhanced quality of life.

The UTHSCT has established close working relationships with other small hospitals across the region and will provide leadership through the NET-CRCH to convene leadership

teams from partnering hospitals for the purpose of increasing the capacity and sustainability of a culture of continuous improvement to deliver the right care, in the right place, at the right time. In order to gain proficiency with quality improvement philosophies and tools, the LCT teams will focus on improving management of patients with CHF. This strategy will not only decrease costs of care but will serve as a model approach within each organization for ongoing quality improvement, safety and efficiency of operations.

- An initial face-to-face orientation meeting of the five LCT teams (2 from the Good Shepherd network) will be held to engage in team-building and establish a specific timeline and outcomes to be undertaken at each facility.
- NET-CRCH staff will facilitate review and presentation of various QI programs and tools. The group will work through a model process evaluation matrix to demonstrate application of various approaches. QI improvement processes and tools will be selected by each team that will be implemented to enhance a critical delivery point in the continuum of care for CHF patients.
- Thecombined workgroup will establish two quantifiable goals, establish a deadline for completion, and schedule a webinar-based meeting(s) to share experiences and discuss findings as well as next steps. One of the first independent activities will be establishing parameters for data to review.
- Each LCT team will identify a regional "innovator agent" who will serve as an advisor and mentor by rapidly responding to practical implementation questions.
- Each team member will receive support to be an ambassador internally and externally to promote effective approaches and implementation ideas that promote an environment of safety, quality care and efficiency of operation.
- The NET-CRCH facilitator will circulate a "tip of the week" related to QI ideas, safety reminders, success stories, and champion news bits via web messaging and/or social media.
- A series of site visits will be scheduled in which each hospital hosts the LCT teams' workgroups to demonstrate the impact of their selected implementation and present lessons learned.
- At least two face-to-face meetings will be held in DY3 – DY5 to share data, processes, new tools or adaptations.
- As a workgroup, the LCT teams will agree to each implement at least one action a quarter that every site can accomplish in order to raise the floor on performance. Outcomes and challenges will be shared with the group for recognition, problem-solving and encouragement.
- The Learning Collaborative will contribute to the science of QI by developing a manuscript describing the process and outcome for publication in a peer-reviewed journal.

Related Category 3 Outcome Measure(s): As part of the Continuous Quality Improvement activities, process and outcome measures are tracked to guide the region and practice level priorities and resources. Specific Process Milestones include P-1 Organizing the LCT team and beginning the planning process. P-2-establish baseline rates is a process to help the LCT teams to benchmark critical processes. To capture progress on the development and testing of data systems (P-4) is the chosen measure to ~~In addition, this process intense project will include (P-7)~~ conduct rapid improvement cycles as an ongoing improvement measure. The selected Improvement Target is IT-3.2 Congestive Heart Failure 30-day Re-admission Rate. As a non-hospital performing provider, specific improvement metrics are to be determined (TBD).

The project has implications for **Category 4** measures including as patient-centered health care, patient satisfaction, and potentially preventable admissions, re-admissions, and complications.

Relationship to other Projects: Relationship to Other Performing Providers' Projects in the RHP: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure, clinical, and educational expertise to benefit the following RHP project(s):
127278302.1.4 – Increase Training of Primary Care Workforce; Capacity Building through Workforce Development: Training Community Health Workers (CHWs)
127278302.2.1 Expand Patient Centered Medical Homes
127278302.2.19 Pass 3b (127278302.2.8) Establish/Expand Patient Care Navigation Program
127278302.2.15 Pass 3b (127278302.2.3) Implement Palliative Care programs

Relationship to Other Performing Providers' Projects in the RHP: See Learning Collaborative description below.

Plan for Learning Collaborative: The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health. The Center was established for the purpose of engaging in community health service activities within the Northeast Texas region and to promote projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. In this collaborative role the Center plans to accomplish the following

1. Convene internal and external stakeholders who will participate in Regional Health Plan development and facilitation
2. Facilitate Regional Health Plan meetings and communicate function and purpose of the Regional Health Plan
3. Assist with identification of community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project
4. Coordinate efforts within the Regional Health Plan including provision of a platform and process for identifying, improving, and facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence
5. Monitoring outputs, metrics, and intermediate outcomes, coordinating data, and reporting on the progress of the Regional Health Plan
6. Serve as a point of contact for the Regional Health Plan with Texas Health and Human Services
7. Lend scholarly and academic assistance to the design and implementation of DSRIP projects. Serving as a facilitator for regional data transmission will be a key function of the Center, tied closely to evaluation of its success. UTHSCT will participate in a RHP-wide learning collaborative with other providers through the Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: This ambitious, transformative project to systematically apply QI programs to service delivery in a series of clinics within an academic health science center four additional rurally based hospitals in the region (Smith and surrounding counties). This is particularly true where there has been little assessment of current practice capabilities, where there are few personnel resources, and where training in systems engineering initiatives have been limited. Yet, it is well established that the QI model coupled with evidence-based practice guidelines, which uses team-based efforts to provide integrated care, would enhance patient and provider experiences, and reduce costly utilization. These Category 3 outcome measures are selected to demonstrate the benefit of implementing such a model in this setting. The value of this project is justifiable on the basis of:

- Building capacity and sustainability for QI team and process development.
- Enhanced access to integrated specialty care services for CHF for the rural/vulnerable population and to promote early intervention measures.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Implementation of a recognized, best-evidence model of care delivery.
- Promotion of culture change to enhance adoption of quality improvement measures and approaches.

References:

Lang GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

Bonomi AE, Wagner EH, Glasgow RE, VonKorff M. Assessment of chronic illness care (ACIC): a practical tool to measure quality Improvement. Health Serv Res. 2002 June; 37(3): 791-820

Devers KJ, The state of quality improvement science in health: what do we know about how to provide better care? 2011 Urban Institute Research of Record, http://www.urban.org/index.cfm (last accessed 10/17/12)

Provost L, Miller D, Reinertsen J. A Framework for Leadership for Improvement. Cambridge, MA: Institute for Healthcare Improvement; February 2006. Last Modified 9/2011. http://www.ihi.org/knowledge/Pages/Tools/IHIFrameworkforLeadershipforImprovement.aspx (last accessed 10-18-12).

Oujiri J, Ferrara C. The Phoenix Project. Integrating effective disease management into primary care using lean six-sigma tools. http://www.ehcca.com/presentations/qualitycolloquium6/ferrara_2b.pdf

Shortell SM, Bennett CL, Byck GR. Assessing the impact of continuous quality improvement on clinical practice: what it will take to accelerate progress. The Milbank Qtrly 1998 76(4): 593-615.

Texas Department of State Health Services (DSHS). East Texas Community Health Needs Assessment, 2007. Available at http://www.dshs.state.tx.us/easttexas/reports.shtm (last accessed 10-12-2012).

West N. Using Lean Principles for clinical quality improvement. http://www.cfmc.org/files/hospital/gwtg_presentations/Using%20Lean%20in%20QualityImprovement.pdf (last accessed 10/18/12).

127278302.2.17 Pass 3b (127278302.2.6)	**2.8.4**	**2.8.4**	**APPLY SYSTEMATIC APPROACH TO IMPROVE Q/EFFICIENCY FOR CHF PATIENTS**
University Physician Associates			**127278302**
Related Category 3 Outcome Measure(s):	127278302.3.46 Pass 3b (127278302.3.21)	**IT-3.2**	Outcome Domain – 3.2 Congestive Heart Failure 30 Day Readmission

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Target Specific workflows, processes and/or clinical areas to improve Metric 1 P-1.1: Performing Provider review/prioritization of areas/processes to improve upon Baseline/Goal: Submission of Performing Provider report Data Source: TBD Milestone 1 Estimated Incentive Payment: $715,818 **Milestone 2:** P-8 Train providers/staff in process improvement Metric 1 P-8.2: number of trainings held Baseline/Goal: 80% of LCT team members attend training Data Source: Curriculum and training materials Milestone 2 Estimated Incentive Payment: $715,818	**Milestone 3:** P-7 Implement rapid improvement project using proven methodology Metric 1 P-7.1: Rapid improvement cycle Baseline/Goal: Each LCT team documents performance of all steps in the cycle Data Source: Documentation of rapid improvement project Milestone 3 Estimated Incentive Payment: $920,927 **Milestone 4:** P-15 Participate in face-to-face meetings 2x/ year Metric 1 P-15.1: Participate in semi-annual face-to-face meetings organized by RHP Goal: Each LCT is represented at the semi-annual meeting Data Source: Documentation of meeting, agenda, notes Milestone 4 Estimated Incentive Payment: $920,927	**Milestone 5:** P-15 Participate in face-to-face meetings at least twice per year Metric 1 P-15.1: Participate in semi-annual face-to-face meetings organized by RHP Goal: Each LCT is represented at the semi-annual meeting Data Source: Documentation of meeting, agenda, notes Milestone 5 Estimated Incentive Payment: $968,567 **Milestone 6:** I-15: Increase # process Improvement champions Metric 1 I-15.1: # of Designated quality champions Goal: Increase the designated quality champions in each hospital by 10% over baseline LCT team members Data Source: Training documentation Milestone 6 Estimated Incentive Payment: $968,567	**Milestone 7:** I-15 Increase the number of process improvement champions Metric 1 I-15.1: Increase the number of designated quality champions Goal: Increase the designated quality champions in each hospital by 10% over DY4 Data Source: Training session documentation Milestone 7 Estimated Incentive Payment: $1,537,059 Given the nature of the project and the selected Category 3 Outcome Improvement target of reduction in CHF readmissions, it is anticipated that 600 patients will receive at least one service during this demonstration project.
Year 2 Estimated Milestone Bundle Amount: $1,431,636	Year 3 Estimated Milestone Bundle Amount: $1,841,854	Year 4 Estimated Milestone Bundle Amount: $1,937,134	Year 5 Estimated Milestone Bundle Amount: $1,537,059

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $6,747,683

Project Option: 2.15.1 - Integrate Primary and Behavioral Healthcare Services
Unique Project Identification Number: 127278302.2.18 Pass3b (127278302.2.7 (Pass 1))
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center at Tyler (UTHSCT) and its faculty - University Physician Associates (UPA) represent the only academic medical center in Region 1. The UTHSCT is a recognized provider of graduate medical education (GME) including family medicine, internal medicine, and occupational medicine residency programs and continuing medical education (CME) to enhance physician's commitment to lifelong learning. It is also accredited to sponsor pharmacy continuing education.

Intervention: As a new initiative, a behavioral health team will be hired to design, implement, and evaluate 1) CME training program(s) incorporate behavioral health care into a time limited office visit; 2) integrate behavioral health clinical competency into the Family and Internal Medicine residency curricula; and 3) consult with the primary care providers on complex cases. The project will focus on low behavioral health-low physical health complexity/risk (Quadrant 1) and low behavioral health-high physical health complexity/risk (Quadrant III) of the Four Quadrant Model in a fully integrated system of care (Level V).
Need for the Project: About half of all mental health services in the U.S. are provided by primary care physicians however, very few have any training to either assess or treat behavioral health needs of their patients. The majority of counties in Region 1 have shortages in primary care professionals and the DSHS estimates that more than 85,000 individuals in the region have a serious mental illness. Of the 1.5 million people who reside in Region 1 of the state, about 54% are either uninsured or enrolled in some form of publicly funded insurance.

Target Population: The target population includes UTHSCT primary care physicians, 8 second year family medicine residents (DY 3 -5 = 24), and 18 second year internal medicine residents (DY 4 -5 = 32). UTHSCT patient records indicate 11,976 unique medical record numbers for a recent 12 month period. The payer mix for that period was 18.3% Medicaid and 25.1% self-pay. The Internal Medicine continuity clinic for residency training does not yet have an established patient base. We expect about 1/3 of patients benefitting from this project will be Medicaid eligible.

Category 2 Expected Patient Benefits: The team will establish a baseline of the target patient population in DY2-3; I-1.8 patients receiving integrated behavioral and primary care will improve 5% in DY4 compared to baseline and 10% in DY5 compared to baseline. Metric I-9 is a measure of coordination of care. The percent of patients with a behavioral and primary care treatment plan will improve by 3% over baseline in DY4 and by 7% over baseline in DY5. Without a baseline for this innovative project, it is estimated that 900 patients will receive 1080 services over the course of the demonstration project.

Category 3 Outcomes: IT-1.8 our goal is to increase in DY4 and DY5 by X% (TBD), the number of patients over the baseline (TBD in DY3), who are assessed for depression (PHQ-9) and have a documented treatment plan. IT-1.9 improve in DY4 and DY5 by X% (TBD) the number of patients over baseline established in DY4 whose depression is in remission at 12 months.

Project Narrative

Project Description: It is estimated that about one half of all mental health services in the U.S. are provided by primary care physicians. (Searight 2009) This approach has been successful in many respects leading to a recommendation that the primary care physician should be the first stop in a stepped-care approach. (Haaga 2000) At least one barrier to universal implementation of this standard of care is the challenge experienced by residency programs to incorporate behavioral health training into the curriculum in a fashion that enables the resident to gain competence and confidence in addressing behavioral health needs in the context of primary care practice. (Triana, 2012)

A team of behavioral health professionals will be hired to 1) provide CME **training** for primary care providers –physicians, mid-level providers, and nurses to learn assessment, behavioral health counseling skills, and techniques(such as motivational interviewing (Knight) to incorporate behavioral healthcare into a time limited office visit; 2) collaborate with the medical education program directors for family and internal medicine residency programs at two institutions to incorporate behavioral health clinical skills into the curriculum; and 3) consult with the primary care providers for more complex cases. Interactions between members of the behavioral health team and primary care providers will be facilitated by use of the tele-mental infrastructure project that will provide bi-directional connectivity to facilitate individual case consultation as well as individual, small group, and classroom instruction. The planned intervention meets Level 5 criteria (Close Collaboration in a Fully Integrated System) that will 1) increase access to care for patients who have behavioral health issues, 2) provide services in an environment where the patient is most comfortable, and 3) provide direct patient care training for the delivery of holistic health care for physicians in training.

The **goal** of this project is to increase the number of primary care physicians (in practice and in training) who can effectively and routinely include behavioral health screening, counseling, and treatment, including psychopharmacology, to deliver integrated care. The demonstration project will be implemented with primary care physicians affiliated with Good Shepherd Medical Center (GSMC) and with UPA clinics affiliated with the UTHSCT.

Challenges exist to achieving the goal of this project. Primary care physicians have demanding schedules, therefore arranging time to complete an ongoing, although short-term physician scheduling training will be needed. Physician champions will be engaged to identify and support the involvement of their peers. Similarly, the residency curriculum for both family medicine and internal medicine is very demanding; residency programs are challenged to train physicians to deliver mental health care. (Himelhock, Ehrenreich 2007) The model curriculum was designed to address this challenge. The medical education leadership team for both programs is committed to including behavioral health training into their programs. Despite the overall shortage of behavioral health professionals, the academic medical center has initiated a plan to assemble the requisite team of behavioral health professionals to support this project.

The **expected outcome** at the conclusion of this project is that in DY5, 10% of primary care physicians who complete the CME program will routinely deliver behavioral health care as part of their primary care practice for a targeted population; and 50% of third year family medicine and internal medicine residents will demonstrate the competence and confidence to screen, counsel, and treat primary care patients who are in Mauer's Quadrants I and III.

Starting Point/Baseline: The number of primary care physicians in the service areas who currently provide some level of behavioral health care is unknown. Neither residency program includes clinical training for behavioral health diagnoses, treatment, or the development of an integrated care plan as part of their current curriculum; both residency program directors recognize the need and opportunity to include this important skill set in their **curricula and clinical training**. There are 8 second year residents in the family medicine program each year. 2012 is the inaugural class of internal medicine residents, there will be 18 second year students each year of the demonstration project. They will work with the behavioral health team to accomplish that goal, establish **performance metrics** and reinforce the routine delivery of integrated care for their patients.

Activities in DY2 and DY3 of this project will involve a behavioral health team representative(s) and physician champions in the **identification of primary care physicians** to participate in this demonstration project. A target population to receive integrated services will be identified using evidence-based indicators of behavioral health issues (specifically depression) documented to co-exist with specific chronic disease conditions. These physicians and their targeted patient population will serve as **the baseline** for improvement metrics. Also during this timeframe, the residency training programs with input from the behavioral health team, will review the model curriculum, determine any adaptations needed and incorporate the modules into the schedule for second year residents.

Rationale: The Mental Health Gap Analysis prepared by the National Council for Community Behavioral Healthcare (2009) indicates that over 392,000 indigent, uninsured people in Texas need mental health services. Of the nearly 1.5 million people who reside in Region 1 of the state, about 54% are either uninsured or enrolled in some form of publicly funded insurance. In concert with being the most rural region in the state, 25 of the 28 counties in the region are entirely or have a service area within the county that is Medically Underserved. (Combs 2008) The Northeast TX region has a behavioral health professional shortage and significant unmet needs. The UPA clinics are located in Upshur and Rusk counties which are entirely MUA counties; as well as Smith County which draws from surrounding, rural and medically underserved Cherokee, Van Zandt, Upshur, Rains, and Rusk counties. Primary care clinics affiliated with GSMC serve patients from a wide geographic area; most typically a seven county area that includes Cass, Marion, Harrison, Camp, Wood, Panola and Gregg.

Social and environmental factors are major determinants of health and disease outcomes; yet, there is little capacity within the current primary care workforce to help patients address these factors. Compounding the issue of access to behavioral health services is the current and projected workforce shortage. Information reported by the Hogg Foundation indicates that the Texas per capita workforce especially among psychiatrists, social workers and family/marriage counselors is decreasing. A substantial number of those professionals currently

practicing in Texas are reaching retirement age. (RHP Planning Summit, 2012) Further, data indicates unmet health care needs for persons with severe behavioral health issues as well as unmet behavioral health needs among individuals who have chronic illnesses.

Growing evidence suggests that "patients with chronic disease conditions do better when they receive effective treatment within an integrated system with self-management support and regular follow-up."(Epping-Jordan, Pruitt et al. 2004) Studies suggest that nearly half of all mental health services are delivered by primary care physicians and, that this is both efficient and cost-effective. (Searight 2009, 2007) Despite this increased burden on primary care providers to recognize, diagnose and treat mental/behavioral health problems; they are often not adequately prepared to do so. (Triana 2012)

In addition, current research and planning for the integration of physical and behavioral healthcare has determined that persons with mild to moderate mental health and substance use conditions should be served in primary care and persons with Serious Mental Disorders (SED) and Serious Mental Impairment (SMI) generally require specialty behavioral healthcare services. (Mauer 2006) Therefore, integrating physical and behavioral healthcare services can support early diagnosis and treatment of behavioral conditions resulting in more cost-effective care thereby reducing the inappropriate burden on specialty care. This approach creates availability for patients with more serious care needs to access the right level of care.

To implement this transformation project, a behavioral health professions team comprised of a psychiatrist, 2 Advanced Practice Professionals, and a Licensed Personal Counselor will be hired to facilitate the integration of care through education, consultative support, and referral from primary care providers. Community Health Workers who have received additional training in behavioral health care will function with the integrated team to provide care plan support as determined by the team.

a) Primary care physicians who staff UPA clinics and who supervise medical residents plus primary care physicians associated with (GSMC) in Longview, TX will be among those involved with this demonstration project. Selection of sites for the integration program, continuing medical education for physicians and clinic personnel will begin in DY2. With support from the behavioral health professional team members, they will be supported as mentors to medical residents, serve as role models and reinforce the inclusion of behavioral health care as part of their primary health care practice. In addition, second year resident physicians will complete the model four week behavioral health curriculum in order to gain the skills and confidence to assess and treat behavioral health needs of patients in the primary care setting. These clinic patients will benefit from the integration of behavioral health services as part of their primary health care. The targeted patients will include those who are in Quadrants I and III of the Chronic Care Model adapted by Mauer: Quadrant 1- low behavioral health and low physical health needs and Quadrant III -low behavioral health and high physical health needs. (Mauer 2006)

b) Provider agreements: Fulfilled

c) In DY2 the project data manager will be responsible for working with the clinical team, IT, and QI staff in to order to develop and implement user-friendly and secure data collection, sharing and reporting mechanisms, and track patient survey results.

d) In order to integrate behavioral health services with established primary care practice, a psychiatrist, two Advanced Practice Providers, a Licensed Personal Counselor, and two

Community Health Workers will be hired to provide clinical consultations using the tele-mental infrastructure project capabilities, and receive referrals from primary care as needed.
e) The behavioral health team will deliver continuing medical education curricula to support primary care physicians participating in this project to develop skills using evidence-based tools to integrate behavioral health services into their practice.

The behavioral health team will work collaboratively with the Physician in Chief, Chair of Family Medicine, the Director of Medical Education and the Internal Medicine Residency Director to review and adapt the model curriculum (Triana, et.al, 2012) to include psychopharmacology use with motivational interviewing techniques. They will develop an implementation plan to address the programmatic requirements, system support needed, and create a shared vision for implementing, continually evaluating, and reinforcing the skills needed to deliver integrated services. Focused training for second year residents will begin in DY3. Instructional activities follow progressive skill set development for counseling and reflective listening, health behavior change, counseling for depression, and counseling for anxiety.

The integrated team will meet weekly during an initial planning period in DY2 and regularly thereafter with a focus on preparation for implementation and evaluation. Weekly Clinical case conferences (weekly and as-needed) using the tele-mental network, will provide ongoing teaching opportunities and facilitate joint development of treatment plans among members of integrated team and documented for joint reference. Community Health Workers will be fully engaged with the integrated team contributing both services and feedback from patient interaction.
f) Primary care clinics are in various stages of implementation with the use of electronic health records. Some software add-ons or programming may be needed to efficiently capture standard data that can be accessed by all members of the integrated care team. The project data manager will work with IT to assure the project data and reporting needs are met.
g) Legal agreements – fulfilled; **h)** Utilities/building services - fulfilled
i) During DY2 and 3 project team members will work together to develop procedures and protocols with input from systems specialist, data analyst, and clinical team members to assure the data collection standards are reasonable, secure, meet reporting requirements, track essential data to monitor clinical outcomes to guide ongoing patient care, as well as achieving other reporting and **Quality Improvement** metrics.
j) Team meetings will be held at least monthly to address quality improvement opportunities for the project. The team will select an evidence-based QI program that is a best fit for the system protocols. The meeting agenda will include "lessons learned" and opportunities as standing discussion items for the following elements of project implementation: a) Protocols for clinical care, b) referral and loop-back processes, c) medical record access between primary and behavioral health care providers and d) other system processes.

This project option addresses RHP community need **CN. 2:** Insufficient access to mental and behavioral health services, and community need **CN.6** Efficiency in and effectiveness of health care delivery.

Related Category 3 Outcome Measure(s): Process outcome measures for DY2 and DY3 have been selected to reflect the critical processes of planning and team building to establish data sources available and needed. These include project planning (P-1) and establishing baseline rates (P-2). The Improvement targets for this demonstration project have been selected from Outcome Domain 1 (OD-1) Primary Care and Chronic Disease Management. It is well documents that depression is a frequent co-morbidity among chronic disease patients. (Epping-Jordan, 2004) Other **evidence** validates that trained primary care physicians can provide behavioral health needs assessment and service effectively during a regular office visit. (Searight, Triana) In order to assess two critical measures IT-1.8 (non-standalone) has been selected to assess the effectiveness of physicians integrating behavioral health screening and establishing treatment plans for clinical depression using the widely accepted (PHQ9). A second outcome metric **IT-1.9 standalone – depression remission at 12 months,** was selected to reinforce the integration model so that physicians can see the benefit to their patients' quality of life, an increased satisfaction with the quality of care delivered, and recognize efficiency in the system. This metric also indirectly tests the effective deployment of Community Health **workers to provide coaching and care plan adherence for patients with complex issues.** The project could also have implications for **Category 4** measures, e.g. patient satisfaction, and potentially preventable admissions/re-admissions/complications.

Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure, clinical, and educational expertise to benefit the following RHP project(s):
127278302.1.4 Increase training for primary care workforce - CHW certification program
127278302.1.10 Pass 3b (127278302.1.3) Implement technology-assisted services for behavioral health care
127278302.2.1 Expand primary care capacity – UPA
127278302.2.14 Pass 3b (127278302.2.2) Expand primary care capacity – GSMC
127278302.2.19 Pass 3b (127278302.2.8) Implement Patient Care Navigator

Relationship to other Projects in the RHP: Successes and lessons learned will be shared with other RHP members through the regional learning collaborative described below.

Plan for Learning Collaborative: The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health (The Center). The Center will: 1) engage in community health service activities within the Northeast Texas region and 2) enhance, promote, coordinate, and support faculty and student projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. UTHSCT will participate in a RHP-wide learning collaborative with other providers through the Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementing of DSRIP projects.

Project Valuation: Implementation of this ambitious project to integrate behavioral health care into primary care practice represents a significant contribution to address unmet behavioral

health care needs for a large, rural and medically underserved population in region 1. The value of this project is justifiable on the basis of:

- Two tiered training program with the support of a behavioral health care team to integrate services delivered by primary care providers
- Build capacity to transform primary care medicine for the next generation by equipping them with behavior health practice skills during residency following an evidenced based model curriculum. 82.5% of UTHSCT Family Medicine residency graduates stay in TX.
- Implement training and consultation utilizing tele-mental infrastructure between behavioral health professionals and clinic sites.
- Delivery of integrated services to patients in order to improve quality of life, quality of care, and improve efficiency of the delivery system.

References

Behavioral Health/Primary Care integration and the Person-Centered Healthcare Home, 2008 SAMHA-HRSA Center for Integrated Health Solutions. http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions

Coleman K, Austin BT, Brach C, Wagner EH, (2009) Evidence on the chronic care model in the new millennium. Health Affairs Vol. 28 Issue 1, p75-85, 11p.

Collins C, Hewson DL, Munger R, Wade T (2010) Evolving Models of Behavioral health Integration in Primary Care, Milbank Memorial fund. http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf

Combs, S Texas in Focus: Upper East Texas, 2008. Available at http://www.window.state.tx.us/specailrpt/tif/uppereast/ (last accessed 9/6/2012).

Epping-Jordan JE, Pruitt SD, Bengoa R, Wagner EH, (2004) Improving the quality of health care for chronic conditions. Qual Saf Health Care 13(4):299-305.

Haaga DA: **Introduction to the special section on stepped care models in psychotherapy.** *J Consult Clin Psychol* 2000, **68(4):**547–548.

Himelhoch S, Ehrenreich M: **Psychotherapy by primary-care providers: results of a national sample.** *Psychosomatics* 2007, **48(4):**325–330.

Hogg Foundation for Mental Health: http://www.hogg.utexas.edu (last accessed 10/10/12)

Knight KM, McGowan L, Dickens C, Bundy C. A systematic review of motivational interviewing in physical health care settings. BJHP 2006 11: 319-332.

Mauer, B. 2006. Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices. Rockville, MD: National Council for Community Behavioral Healthcare. Available at http://www.thenationalcouncil.org/galleries/business-practice National Council on Community Behavioral Healthcare, U.S.DHHS 2009.

Searight HR: **Efficient counseling techniques for the primary care physician.** *PrimCare* 2007, **34(3):**551–570. vi-vii.

Searight R: **Realistic approaches to counseling in the office setting.** *Am Fam Physician* 2009, **79(4):**277–284.

Triana AC, Olson MM, Trevino DB. A new paradigm for teaching behavior change: implications for residency training in family medicine and psychiatry. *BMC Medical Education* 2012, 12:64. Available at http://www.biomedcentral.com/1472-6920/12/64 (last accessed 9-20-2012).

127278302.2.18 Pass3b (127278302.2.7 Pass 1)	2.15.1	2.15.1 ~~a-j~~ A,C-F, J	INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	127278302.3.47 Pass 3b (127278302.3.22) 127278302.3.48 Pass 3b (127278302.3.23)	3.IT-1.8 3.IT-1.9	Depression Mgmt: Screening & Treatment Plan for Clinical Depression Depression Management: Remission at Twelve Months	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-5 Develop integrated sites reflected in the number of locations & providers participating in the integration project Metric 1 P-5.3: Number of BH providers newly located in primary care clinics Baseline: 0/Goal: 2 behavioral health providers newly located in primary care clinics Data Source: Project data Milestone 1 Estimated Incentive Payment : $1,295,464	**Milestone 2** P-5: Develop integrated sites reflected in the number of locations & providers participating Metric 1 P-5.3: Number of BH providers newly located in primary care clinics Baseline 2/Goal: Hire 2 additional BH providers newly located in primary care clinics Data Source: Patient records Milestone 2 Estimated Incentive Payment: $3,278,474		**Milestone 3** : I-1.8 Integrated Services Metric 1 I.8.1-Individuals receiving both physical and behavioral health care in project sites Goal: 5% of individuals seen in the project sites receive both physical and behavioral services. Data Source: Medical records Milestone 3 Estimated Incentive Payment: $1,617,072 **Milestone 4** I-9 Coordination of Care Metric 1 I.9.1 Increase percentage of individuals with a treatment plan developed and implemented with primary and behavioral care expertise Goal: 3% of target population have treatment plan developed and implemented with BH & PC expertise Data Source: Medical records Milestone 4 Estimated Incentive Payment: $1,617,072	**Milestone 5:** I-1.8 Integrated Services Metric 1 I.8.1-Individuals receiving both physical and behavioral health care in project sites. Goal: 10% of individuals seen in the project sites receive both physical and behavioral services. Data Source: Medical records Milestone 5 Estimated Incentive Payment: $1,372,329 **Milestone 6** I-9 Coordination of Care Metric 1 I.9.1 Increase percentage of individuals with a treatment plan developed and implemented with primary and behavioral care expertise Goal: 7% of target population have treatment plan developed and implemented with BH & PC expertise Data Source: Medical records Milestone 4 Estimated Incentive Payment: $1,372,329 Estimated that 900 patients will receive 1080 services over the course

127278302.2.18 Pass3b (127278302.2.7 Pass 1)	2.15.1	2.15.1 ~~a-j~~ A,C-F, J	INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	127278302.3.47 Pass 3b (127278302.3.22)	3.IT-1.8	Depression Mgmt: Screening & Treatment Plan for Clinical Depression	
	127278302.3.48 Pass 3b (127278302.3.23)	3.IT-1.9	Depression Management: Remission at Twelve Months	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
				of this innovative demonstration project.
Year 2 Estimated Milestone Bundle Amount: $1,295,464		Year 3 Estimated Milestone Bundle Amount: 3,278,474	Year 4 Estimated Milestone Bundle Amount: $3,234,144	Year 5 Estimated Milestone Bundle Amount: $ 2,744,658
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $10,552,740				

Project Option: 2.9.1 - Establish/Expand a Patient Care Navigation Program
Unique Project Identification Number: 127278302.2.19 Pass 3b (127278302.2.8)
Performing Provider/TPI: UTHSCT-MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: The University of Texas Health Science Center Tyler (UTHCT) sits on a 614 acre site northeast of Tyler Texas. In 1977, the institution joined the University of Texas System, with a primary three-fold mission to conduct patient care, research, and education in the treatment of pulmonary and heart disease. Currently, the academic center consists of a 109 bed hospital with over 20 outpatient clinics and 30 areas of specialty, including adult and pediatric pulmonary and infectious disease, cardiology, oncology, family practice and internal medicine, occupational medicine, asthma, allergy, lung disease, diabetes, aging, and gastroenterology.
Intervention(s): UTHSCT's hospital and primary care clinics will employ 6 teams of chronic disease patient navigators paired with community health workers to enhance the transfer of information and reinforce medical recommendations from the point of hospital discharge and/or medical home visits in order to improve patient adherence and influence patient disease self-management.

Need for the Project: The region has a higher than average prevalence of certain chronic diseases, and admission rates for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and mortality rates from heart disease and chronic lung disease are among the highest in the state. From FY 2011 (09/01/2010-8/31/2011), there were 40,625 visits from patients with chronic diseases and co-morbidities (cardiovascular disease, respiratory disease, and diabetes). This accounted for 18% of the total visits. Furthermore services such as prescription services, imaging, lab tests, evaluation and management procedures, and ED charges had 36.03% contributed to chronic disease diagnoses.

Target Population: The PN program will provide navigation services to the region's populations whom are identified at high risk for disconnect from institutionalized healthcare. UTHSCT will target the 18% of total visits as described above related to chronic disease and co-morbidities. The PN will identify the frequent ED users and will utilize their cultural competency training from the six week training program they will undergo upon employment to prevent inappropriate ED utilization.

Category 2 Expected Patient Benefits: The PN program will seek to conduct a needs assessment and establish patient navigation services with DY 2; increase the percent of target population enrolled in the PN program and increase patient engagement in DY 3; increase the number of PCP referrals for patients without a medical home in DY 4; ~~and reduce the number of ED visits among those enrolled in the navigation program in DY 5.~~ This project is expected to cover a base patient/client population of 850, with unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, up to 85 patients/clients will receive or be engaged in patient

navigation services by DY5, who did not previously have direct access to such services. The improvement milestone selected for this project to increase the number of PCP referrals to patients without a medical home whom utilize hospital services directly reflects the quantitative impact of the project on the population served.

Category 3 Outcomes: After completing project planning and establishing baseline rates in DY 2, IT-9.2, will be implemented which is a reduction of ED visits related to COPD, Asthma, Diabetes, CHF, CD, and BH each year from DY 3 to DY 5. Percentage of decrease will be determined following the establishment of baseline rates in DY 2.

Project Narrative

Project Description: UTHSCT's hospital and primary care clinics will employ 6 teams of chronic disease Patient Navigators paired with Community Health Workers (CHWs), who will be trained by faculty and staff of the UTHSCT in **chronic care, behavioral health, and cultural competency**. These teams will enhance the transfer of information and reinforce medical recommendations from the point of hospital discharge and/or medical home visits in order to improve patient adherence and influence patient disease self-management among UTHSCT **frequent ED users as a part of a preventable ED reduction program**. The patient navigator is the link between the patient and the medical home to reduce barriers to care and coordinate follow-up and screening. The CHW will work with the patient navigator to bridge the gap of transferring medical recommendations from the health care system to the patient. The CHW will provide reinforcement of the patient's care plan in the context of appropriate social, emotional, educational, and self-management skills, inform the patient navigator of barriers to adherence, and contribute electronic health record (EHR) updates accessible by all team members. Two community liaisons, who will also be trained as CHWs, will facilitate team assignments to patient participants and conduct outreach/educational efforts in coordination with external partners. Patient status, progress, and challenges will be reviewed through regular direct communication between the patient navigator and CHW and noted in the EHR. In- person team meetings with the primary care physician will be scheduled with a periodicity based on the duration of care (typically 12 to 24 weeks).

The **goal** of this project is to utilize **innovative health care personnel such as community health workers and bachelors level health professionals including nurses, social workers, health service professionals, and public health professionals as patient navigators** to provide enhanced social support and **culturally competent care** to vulnerable and/or high-risk patients in region 1. Patient navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators will assist in connecting patients to primary care physicians for **preventive care**, specialty care and/or the patient centered medical home, as well as divert non-urgent care from the Emergency Department to site-appropriate locations.

Employment of the CHWs to registered apprenticeship sites, are key steps toward sustainability of this model and expands career opportunities for new health care workers. Moreover, if an unemployed or underemployed person is hired into an apprenticeship position, the business can petition the DOL for a "wage opportunity" tax credit. Once registered, the

business has access to other avenues for funding under the Workforce Investment Act. Apprenticeship programs are approved for veterans under the GI Bill. Texas also has funds to subsidize the cost of apprenticeship positions. It is anticipated that the successes achieved and transformation of care delivery demonstrated here will make it possible to sustain the patient navigator/community liaison model at UTHSCT combined with community employment opportunities for CHWs.

The Chronic Care Model (CCM) and its expansions (Barr, Robinson et al. 2003; Epping-Jordan, Pruitt et al. 2004) offer a conceptual, evidence-based framework for designing interventions which integrate community, health system, and individual-level components. The proposed model will incorporate a more proactive use of information systems and decision support to enhance delivery system design and guide the application of self-management tools for the patient. The self-management support program is expected to enhance health-literacy and disease-specific knowledge; examples include providing **access to care management and/or chronic care management, and education in chronic disease self-management**. Increased monitoring of health care quality measures such as those adopted for meaningful use in EHRs, progress in achieving behavioral changes, and reduction in high cost utilization (ambulatory care sensitive emergency room visits, hospital admissions and readmissions) are all expected to be favorable impacts on the UTHSCT patient population in Northeast Texas.

Two notable **challenges** have been identified concerning this proposed project. The first relates to the belief that improving clinical quality will reduce health care costs. (Rauh, Wadsworth et al. 2011) Though this may seem intuitive, prior demonstration projects have yielded disappointing results. (Ayanian 2009; Peikes, Chen et al. 2009) Nonetheless, findings do seem to suggest that coordinators who work closely with physicians and interact directly with patients had better financial outcomes; as indicated in the model proposed here. Other studies support the success of telephone-delivered physical activity and dietary change interventions, including their cost effectiveness. (Goode, Reeves et al. 2012) A second limitation deals with collection of evaluation information, specifically, the potential for selection bias among participants. (Pearson, Mattke et al. 2007) While individuals who choose to participate may be more motivated toward improved health, this source of bias will be reduced by maximizing participation among all eligible participants. **Quality improvement initiatives** such as identifying lessons learned, project impacts and opportunities for a broader reach of patients will be assessed continuously throughout the project.

The **expected outcome** at the conclusion of DY 5 is to have 6 teams of Patient Navigator and CHW pairs employed within the UTHSCT system and clinics. This project is expected to cover a base patient/client population of 850, with unique services not previously readily available to this group. This population includes a large proportion of vulnerable, indigent, and Medicaid patients. Specifically, up to 85 patients/clients will receive or be engaged in patient navigation services by DY5, who did not previously have direct access to such services. The improvement milestone selected for this project to increase the number of PCP referrals to patients without a medical home whom utilize hospital services directly reflects the quantitative impact of the project on the population served.

Starting Point/Baseline: This is a new program, and the patient navigator role has not yet been

utilized within the UTHSCT system. From FY 2011 (09/01/2010-8/31/2011), there were 40,625 visits from patients with **chronic diseases** and **co-morbidities (cardiovascular disease, respiratory disease, and diabetes**). This accounted for 18% of the total visits. Furthermore services such as prescription services, imaging, lab tests, evaluation and management procedures, and ED charges had 36.03% contributed to **chronic disease diagnoses**. The annual total cost of care for this group of chronic disease patients was $23,561,346. With the implementation of the patient navigator program, small deductions of just 2% would create considerable **savings**.

Rationale: According to the U.S. Census Bureau, the population of Texas exceeded 25 million in 2010. Not unlike the rest of the country, Texas is plagued by the rising cost of health care, largely attributable to chronic diseases which account for 3 in 4 deaths. (Combs, 2008) Unhealthy behaviors (poor nutrition, tobacco use, inactivity) are important influences. In 2009, two-thirds of all adult Texans were overweight or obese. (Combs, 2011) Upper East Texas is much more rural than Texas as a whole with a much larger share (15 percent) of residents over the age of 65. (Combs, 2008) The region has a higher than average prevalence of certain chronic diseases, and **admission rates for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)**, and mortality rates from **heart disease** and **chronic lung disease** are among the highest in the state (Combs 2008; Jackson, Suzuki et al. 2011; Jackson, Suzuki et al. 2011). The population of region 1 is 71 percent white, 15.6 percent black, and 11 percent Hispanic. Hispanics are among the fastest growing segment. Roughly one-fourth of the region's counties are considered to be health professional shortage areas; costs to the region's hospitals alone due to heart disease, congestive heart failure, and stroke in 2005 approached $700 million. In 2007, the Texas Department of State Health Services (DSHS) undertook an East Texas community health needs assessment (ETCHNA) to document the scale of health issues in the region. (Texas Department of State Health Services 2007) This region of nearly 1.5 million population corresponds to the same 35 county service area of Northeast Texas from which the University of Texas Health Science Center at Tyler (UTHSCT) and its clinics draw their current active patient base. Demographic and epidemiologic information obtained from the ETCHNA indicates a smoking prevalence of nearly 27 percent compared with a state rate of 20 percent, higher regional rates of inactivity, and higher rates of high blood pressure in African Americans, whites, and Hispanics. Notably, the majority of counties in Northeast Texas also have higher rates of **preventable hospitalizations for pneumonia**, **congestive heart failure, high blood pressure, asthma, COPD, and diabetes** compared to the rates for Texas. Further, it was estimated that over 85,000 individuals regionally have a serious **mental illness**, with well over 100,000 needing treatment for **alcohol/drug** use.

The PN and CHW program will provide navigation services to these populations described above whom are at **high risk for disconnect** from institutionalized healthcare. The PN will identify the **frequent ED users** and will utilize their **cultural competency** training from the six week training program they will undergo upon employment to **prevent inappropriate ED utilization**. CHW's will be **deployed** to the target population's homes and will report back to the navigator **barriers and challenges** the patient is facing to **access of care** and **compliance** with care regimens. The PN will then help the patient with resources and tools to **reduce** these **barriers** and ensure patients are receiving **timely and appropriate primary** and **preventive**

care. Two community liaisons will be employed who will be responsible for **health education** and promotion programming within the target population; and will offer an educational series and programs to **enhance care management**, **self-management**, and **chronic disease/behavioral health** education. The program will undergo **continuous** and rigorous **quality improvement** assessments, to uncover **barriers to patient's success** and **identify interventions** that have been **successful**.

The PN and CHW program will meet the community needs by addressing community need number (CN.1) insufficient access to primary and specialty health care services; (CN. 2) insufficient access to mental/behavioral health care services; (CN.3) high rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer; and (CN.4) high costs due to potentially preventable hospital admissions/readmissions.

Related Category 3 Outcome Measure(s): DY 2 is comprised of two process milestones. The first process milestone is P-1 Project Planning which will consist of engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. The second process milestone is P-2 Establishing Baseline Rates in which the PN program administration will work to establish and then report baseline numbers of the target patient population whom have ED visits related to COPD, Asthma, Diabetes, CHF, CD/HT and BH/SA. DY 3 is comprised of one process milestone and one outcome improvement target. The process milestone is P-3, the development and testing of data systems that will hold data and help with reporting of PN and CHW patient flow and disease outcomes. The outcome improvement target, IT-9.2, will measure the reduction of ED visits among patients followed by the PN/CHW teams who have had past admissions related to COPD, Asthma, Diabetes, CHF, CD/HT and BH/SA. DY 4 is comprised of a single outcome improvement target; IT-9.2, which will measure the reduction of ED visits among patients followed by the PN/CHW teams who have had past admissions related to COPD, Asthma, Diabetes, CHF, CD/HT and BH/SA. DY 5 is comprised of a single outcome improvement target, IT-9.2, which will measure the reduction of ED visits among patients followed by the PN/CHW teams who have had past admissions related to any chronic or behavioral health conditions.

Rationale for Outcome Measures: As stated above in the rationale, the region has a higher than average prevalence of certain chronic diseases, and admission rates for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and mortality rates from heart disease and chronic lung disease are among the highest in the state. The majority of counties in Northeast Texas also have higher rates of preventable hospitalizations for pneumonia, congestive heart failure, high blood pressure, asthma, COPD, and diabetes compared to the rates for Texas. Further, it was also estimated that over 85,000 individuals regionally have a serious mental illness, with well over 100,000 needing treatment for alcohol/drug use. Prior research shows that the proposed model will incorporate a more proactive use of information systems and decision support to enhance delivery system design and guide the application of self-management tools for the patient. The self-management support program is expected to enhance health-literacy and disease-specific knowledge. Increased monitoring of health care quality measures such as those adopted for meaningful use in EHRs, progress in achieving behavioral changes, and reduction in high cost utilization By implementing the category 2

project: Establish and Implement a Patient Care Navigator and CHW chronic disease self-management program to reduce emergency department visits; the category 3 metrics of reducing ED visits in Asthma, Diabetes, CHF, COPD, Hypertension, and behavioral health and substance abuse can be achieved.

Relationship to other Projects: As a project sponsored by an academic medical center affiliate it is inter-related and contributes infrastructure and educational expertise to benefit the following RHP project(s): 127278302.1.10 Pass 3b (127278302.1.3) Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavioral Health Services in Northeast Texas: CHW's will be trained to work and demonstrate the use of tele-health equipment; this will allow CHW's to visit patients in their home and help connect the patient to the provider through tele-health services to the patient navigator. 127278302.1.9 Pass 3b (127278302.1.2) Improve Access to Specialty Care: CHW's will provide a link from the patient to the patient navigator on the patient's medical home team. The CHW will provide peer to peer support for the patient and ensure the patient is receiving access to the provider in a timely and efficient manner through the patient navigator.

Relationship to Other Performing Providers' Projects in the RHP: Working with CHRISTUS St. Michael, Good Shepherd Medical Center, and Community Healthcore, there will be a collaborative effort to increase primary care capacity. UTHSCT will serve as the training site for CHW's and PN's. Partner organizations listed will serve as sites with possible permanent hiring employment beyond training.

Plan for Learning Collaborative: The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health (The Center). The Center was established for the purpose of: 1) engaging in community health service activities within the Northeast Texas region and 2) enhancing, promoting, coordinating, and supporting faculty and student projects which are broad-based and intended to transform the regional health care delivery system while improving the quality of care delivered. Specific roles of the Center will be to: 1.) convene internal and external stakeholders who will participate in Regional Health Plan development and facilitation; 2.) facilitate Regional Health Plan meetings and communicate function and purpose of the Regional Health Plan; 3.) assist with identification of community needs, the projects and investments under DSRIP to address those needs, community healthcare partners, the healthcare challenges and quality objectives within the Regional Health Plan, and the metrics described in state protocol associated with each project; 4.) coordinate efforts within the Regional Health Plan including provision of a platform and process for identifying, improving, and facilitating DSRIP project proposals and community engagement and outreach initiatives predicated upon principles of best evidence; 5.) monitoring outputs, metrics, and intermediate outcomes, coordinating data, and reporting on the progress of the Regional Health Plan; 6.) serve as a point of contact for the Regional Health Plan with Texas Health and Human Services; 7.) lend scholarly and academic assistance to the design and implementation of DSRIP projects. Serving as a facilitator for regional data transmission will be a key function of the Center, tied closely to evaluation of its success. UTHSCT will participate in a RHP-wide learning collaborative with other providers through the

Center, and will utilize the Center as the clearinghouse for best practices and lessons learned through the process of implementation of DSRIP projects.

Project Valuation: East Texas experiences high levels of chronic health and behavioral health morbidity and the rural uninsured populations remain disproportionately affected. There continues to be limited access to both primary and behavioral health services for poor and vulnerable groups in this region. Inappropriate ED utilization is often tied to poor health outcomes and high costs to society. This project is intended to expand and enhance the capacity of providers within the Northeast Texas region to provide preventive and primary care to these patients whom are at high risk for disconnect from institutionalized healthcare. Patient Navigator programs are felt to hold considerable promise for filling gaps in access for primary and behavioral healthcare delivery. Following a six week PN and CHW training series, a collection of teams will be developed and assigned to identified frequent ED users for navigation and educational follow up and care. Use of Category 3, evidence-based measures will demonstrate improvement in outcomes tied to Right Care in the Right Setting. This capacity investment will help to reduce the financial burden to the regional health care system through provision of care in the appropriate setting and reduced utilization of high cost services such as emergency department visits and unnecessary hospitalization. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing CN.2, insufficient access to mental and behavioral health services; CN.3 high rates of chronic disease; and CN.4 high costs due to PPA's.
- Enhanced access to primary care and behavioral health services for a rural/vulnerable population.
- Developing capacity which can increase access to high quality preventive and primary care.
- Building capacity through training of patient navigator sand CHW teams.
- Providing a platform for integration of primary care and behavioral health.
- Reducing inappropriate ED utilization by providing Right Care in the Right Setting.

References:

aBarr, V.J., Robinson, S., et. al. (2003). "The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model". Hosp. Q. **7**(1): 73-82

aEpping-Jordan, J. E., Pruitt, S. D., et. al. (2004). "Improving the quality of care for chronic conditions." Qual. Saf. Healthcare. **13**(4): 299-305

aRauh, S., Wadsworth, E., et.al. (2011). "The savings illusion: Why clinical quality improvement fails to deliver bottom line results". N. Engl. Journal of Med.

aAyanian, J. (2009). "The elusive quest for quality and cost savings in the medicare program". JAMA **301(**6): 668-670

Peikes, D., Chen, A., et. al. (2009). "Effects of care coordination on hospitalization, quality of care, and healthcare expenditures among medicare beneficiaries: 15 randomized trials." JAMA **301**(6): 603-618

Goode, A., Reeves, M., et. al. (2012). “Telephoned delivered interventions for physical activity and dietary behavior change, an updated systematic review”. Amer. Journal of Prev. Med. **42(**1): 81-88

Pearson, M., Mattke, S., et. al. (2007). “Patient self management Support Programs: An evaluation. Rockville, MD., Agency for Healthcare Research and Quality.

Combs,S.(2008). “Texas in Focus: Upper East Texas.” Retrieved 12/30/2011, From http://www.window.state.tx.us/specialrpt/TIF/

Combs, S. (2011). “Gaining Costs Losing Time 2011 Special Report: The Obesity Crisis in Texas” Retrieved 12/30/2011, From http://www.window.state.tx.us/specialrpt/obesitycost/

Jackson, B.E., S. Suzuki, et. al. (2011) “Geographic Disparity in COPD Hospitalization Rates Among the Texas Population” Respir. Med. **105** (5): 734-739

Texas Department of State Health Services (2007). East Texas Community Health Needs Assessment: 117

127278302.2.19 Pass 3b (127278302.2.8)	***2.9.1***	***2.9.1 A-E***	Implement Patient Care Navigator and CHW chronic disease self-management program to reduce potentially preventable emergency department visits
University Physician Associates			127278302
Related Category 3 Outcome Measure(s):	*127278302.3.49 Pass 3b (127278302.3.24)*	*3.IT-9.2*	*ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 Conduct a needs assessment to identify the patient populations to be targeted with the PN program. – *P-1*: Metric 1 Provide reports – *P-1.1:* Baseline/Goal: identifying target population characteristics, gaps in services, how to identify and manage target population, ideal patients targeted, number of PN to be hired, available clinic data on patient flow. Data Source: Program Documentation, EHR, claims, needs assessment Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,022,942 **Milestone 2** Establish/Expand health care navigation program– *P-2*: Metric 1 Number of people trained as PN, number of navigation procedures, and number of CE sessions for PN.– *P-2.1:* Baseline/Goal: Develop workforce plan for recruitment, training, and education. 6 teams of patient navigators trained. 3 CE sessions	**Milestone 3** Provide care management/navigation services to targeted populations.- *P-3*: Metric 1 Increase the number of percent of targeted patients enrolled in the program-*P-3.1*: Baseline/Goal: number of targeted patients enrolled to the total of targeted patients identified. Increase by 10% Data Source: Enrollment Reports Milestone 3 Estimated Incentive Payment: $ 1,237,895 **Milestone 4** Increase patient engagement- *P-4*: Metric 1 number of classes and/or initiations offered, or number or percent of patients enrolled in the program- P-*4.1*: Baseline/Goal: increase number of patients enrolled in the patient navigator program whom attend engagement programs. Increase by 15% Data Source: class participation lists Milestone 4 Estimated Incentive	**Milestone 5** Increase the number of PCP referrals for patients without a medical home who use the ED, urgent care, or hospital services- *I-6*: Metric 1 Increase medical home empanelment of patients referred from navigator program – *I-6.1*: Goal: increase the number of new patients referred for services from the PN programs that are seen in primary care settings that are new patients to the PN program. Data Source: performing provider data on patient encounters and scheduling records from PN program. Increase by 5% Milestone 5 Estimated Incentive Payment: $ 3,044,302	~~**Milestone 6** Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program- *I-7:*~~ ~~Metric 1 ED visits and/or avoidable hospitalizations – *I-7.1:*~~ ~~Goal: decrease the number of patients who has a ED visit or inpatient admission whom is enrolled in the navigator program.~~ ~~Data Source: EHR, navigation program database, ED records, inpatient records.~~ ~~Milestone 6 Estimated Incentive Payment: $ 1,237,130~~ ~~**Milestone 7** Reduction in ED use by identified ED frequent users receiving navigation services. *I-8:*~~ ~~Metric 1 ED visits pre and post navigation services by individuals identified as ED frequent users. *I-8.1:*~~ ~~Goal: Decrease ED visits among frequents ED users enrolled in the patient navigator program.~~ ~~Data Source: Claims and EHR/registry~~ ~~Milestone 7 Estimated Incentive Payment: $ 1,237,130~~ **Milestone 6** Increase the number of PCP referrals for patients without a

127278302.2.19 Pass 3b (127278302.2.8)	***2.9.1***	***2.9.1 A-E***	Implement Patient Care Navigator and CHW chronic disease self-management program to reduce potentially preventable emergency department visits	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	*127278302.3.49 Pass 3b (127278302.3.24)*	*3.IT-9.2*	*ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
planned and given. Data Source: report numbers and provide PN workforce plan for recruitment, training and education Milestone 2 Estimated Incentive Payment: $ 1,022,942		Payment: $ 1,237,895		medical home who use the ED, urgent care, or hospital services- *I-6*: Metric 1 Increase medical home empanelment of patients referred from navigator program – *I-6.1*: Goal: increase the number of new patients referred for services from the PN programs that are seen in primary care settings that are new patients to the PN program by 10%. Data Source: performing provider data on patient encounters and scheduling records from PN program. Milestone 6 Estimated Incentive Payment: $ 2,474,260 Estimated base patient/client population for this project: 850 Estimated patient/clients engaged in patient navigation services through this project: 85
Year 2 Estimated Milestone Bundle Amount: $ 2,045,884		Year 3 Estimated Milestone Bundle Amount: $ 2,475,790	Year 4 Estimated Milestone Bundle Amount: $ 3,044,302	Year 5 Estimated Milestone Bundle Amount: $ 2,474,260
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 10,040,236				

Project Option: 2.1.2 - Collaborate with an affiliated Patient Centered Medical Home to integrate care management and coordination for shared, high risk patients.
Unique Project Identification Number: 127278302.2.20 Pass 3b (127278302.2.9) (Pass 1)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider: With support from the regional academic medical center, University of Texas Health Science Center at Tyler, this project will be implemented by CHRISTUS ST. Michael Health System which is a 312-bed acute hospital that serves Texarkana, USA for the benefit of its patient population that draws from a radius of approximately 50 miles.

Intervention(s): create protocols and processes to identify patients to be submitted to a medical home to manage the foreseeable challenges such as patients with specified chronic conditions; patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high utilizers of health care services; and patients with particular socioeconomic, linguistic, and physical needs.

Need for the project: Currently there is only one clinic that has removed barriers to access for community members of lesser means and in order to coordinate care between patients in the clinic and chronic patients in the hospital, protocols, processes, and staff needs to be developed and trained to best care for the patients.

Target population: The target population is our patients with chronic illnesses that need coordinated care between the hospital and clinic.

Category 2 expected patient benefits: This project seeks to enroll ~~TBD~~ approximately 950 patients who are high utilizers of healthcare resources and better coordinate their care.

Category 3 outcomes: IT-.X Our goal is to reduce the 30-day potentially preventable all-cause readmission rate from 9.4% currently (SFY12) to 8.7% by DY5.

Project Narrative

Project Description: CHRISTUS St. Michael Health System (CSM) has a goal to create a partnership with a medical home that initiates preventive care and reduces reliance on emergency departments (ED) for primary care. The partnership for medical home coordination of care is with Genesis PrimeCare, an FQHC that operates according to the NCQA Patient Centered Medical standards. A review of recent US Patient Centered Medical Homes (PCMHs) initiatives in the private and public sector found that redesigned PCMH care models were successful in achieving the "triple aims" of health reform: better clinical outcomes, better patient experiences, and lower costs which are aligned with regional goals of reducing the costs of health care and improve quality of care and patient satisfaction. CSM will create protocols and processes in DY2 to identify patients to be submitted to a medical home to manage the foreseeable challenges such as patients with specified chronic conditions; patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high utilizers of health care services; and patients with particular socioeconomic, linguistic, and physical needs. The expected

outcome of this project is to ensure that a process is created to determine which patients are directed to the medical home, education is created for preventative services and the number of patients seeking those services grows by 10% over the number served in DY3. The goal is to have reached approximately 950 individuals by DY5.
Regarding the core components of this project – A) A concerted effort will be made to share information between the clinic and hospital; B) addressing the best way to coordinated care will be developed by following evidenced based best-practice in combination with meeting the needs of the community being served. C-D) There is already a team of case managers, care transition nurses and ED navigators in place but this progress that team will grow as efficiency dictates. E-F) And lastly, as part of the learning collaborative organized by the anchor, processes will be evaluated and adjusted as necessary to create the best environment for patients and associates alike.

Starting Point/Baseline: Many of the patients who receive specialty care at CSM do not have a clearly identified primary care medical home, contributing to fragmentation of care and inefficient use of specialty services for needs that could be more appropriately managed in primary care. Emblematic of this problem are patients with special needs arising in childhood that have aged out of pediatric care. There is a large unmet need for transitions from pediatric to adult medical homes for these patients – many of whom grew up being insured by CHIP/Medicaid who will no longer receive the coordinated primary care to manage their ailments. Coordinated care will be extremely important to help control utilization; with the addition of an aligned primacy care clinic to be built in Texas will support community members in an expanded capacity with an expansion of services over time.

Rationale: In the service area of CSM there is evidence that are barriers to appropriate affordable care, especially for those who are low-income and that population tends to have chronic illnesses. Focusing on coordinated care allows fewer patients to "slip through the cracks" and be better monitored to ensure better compliance. Establishing the protocols to ensure patients that need care coordination will be crucial to the success of this project. The regional need most aligned with this project is in the area of reducing preventable hospitalizations (CN.4). Those hospitalizations are most time the outcomes of not getting proper follow up care or access to a specialist.

Related Category 3 Outcome Measure(s): IT-3.1 All cause 30 day readmission rate 127278302.3.50 Pass 3b (127278302.3.25)

This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardio-respiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. The measure was developed for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. ~~The following was used: the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.~~

Interrelated projects: 127278302.1.11 Pass 3b (127278302.1.5) is essential to the success of this project by creating a preventative care site as the recruitment of specialist to see the more specialized cases especially well working with chronically ill patients.

Relationship to Other Performing Providers' Projects in the RHP: Successes and lessons learned will be shared by other RHP members through the regional learning collaborative described below.

Plan for Learning Collaborative: The RHP Region 1 anchor will sponsor meetings and conferences to facilitate the opportunity for healthcare providers throughout the region and the state to share experiences, challenges, lessons learned and best practices. The leadership team for this project will actively participate in those opportunities.

Project Valuation: By creating efficiencies in the management of patient illness and chronic disease, there is an opportunity to make better use of resources that best serve the long term of health of the Texarkana area population. In order to properly create and implement create and follow policies that follow evidence based practices there will need to be an investment of substantial amount of time be CSM leadership and case management to facilitate an effective process. The desired outcomes will lead to: reduction in preventable readmissions, hospital admissions, and reduced costs of health services to better health management and education. Lastly, this project is closely aligned with community need CN.4.

127278302.2.20 Pass 3b (127278302.2.9)	***2.1.2***	***2.1.2.A-F***	***COLLABORATE WITH AN AFFILIATED PATIENT-CENTERED MEDICAL HOME TO INTEGRATE CARE MANAGEMENT AND COORDINATION FOR SHARED, HIGH-RISK PATIENTS***	
UPA				127278302
Related Category 3 Outcome Measure(s):	127278302.3.50 Pass 3b (127278302.3.25)	*3.IT-3.1*	*All cause 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff Metric 1 [P-2.1]: Performing Provider policies on medical home Baseline/Goal: Establish policies on medical home Data Source: Performing Provider's "Policies and Procedures" documents **Milestone 1** Estimated Incentive Payment $ 1,499,437	**Milestone 2** [P-11]: Identify current utilization rates of preventive services and implement a system to improve rates among targeted population (must select at least one metric). Metric 1 [P-11.3]:Metric: Develop prevention services education management and outreach program Baseline/Goal: create baseline of patients receiving preventative services Data Source: Registry, or other documentation as designated by Performing Provider **Milestone 2** Estimated Incentive Payment: $1,276,721		**Milestone 3** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care Metric 1 [I-17.2]: Number of patients receiving preventive services as indicated by standards of care (e.g., annual wellness exam, vision screening, mammograms, etc.) Goal: Increase number of patients receiving preventative services by 5% over DY3 Data Source: Registry, or other documentation as designated by Performing Provider **Milestone 3** Estimated Incentive Payment: $1,191,806	**Milestone 4** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care Metric 1 [I-17.2]: Number of patients receiving preventive services as indicated by standards of care (e.g., annual wellness exam, vision screening, mammograms, etc.) Goal: Increase number of patients receiving preventative services by 10% over DY3 Data Source: Registry, or other documentation as designated by Performing Provider **Milestone 4** Estimated Incentive Payment: $1,015,377
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,499,437	Year 3 Estimated Milestone Bundle Amount: $1,276,721		Year 4 Estimated Milestone Bundle Amount: $1,191,806	Year 5 Estimated Milestone Bundle Amount: $1,015,377
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $4,983,301				

Project Option: 2.12.2 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population
Unique Project Identification Number: 127278302.2.22 Pass 3b (127278302.2.11)
Performing Provider/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider: With support from the regional academic medical center, University of Texas Health Science Center at Tyler, this project will be implemented by CHRISTUS ST. Michael Health System which is a 312-bed acute hospital that serves Texarkana, USA for the benefit of its patient population that draws from a radius of approximately 50 miles.

Intervention(s): This project will expand the use of mobile device technology to better manage chronically ill patients in an outpatient setting.

Need for the project: We currently only have a one care transition nurse using the mobile device and as the safety net hospital for this community more members can be served with this product to increase efficiency and reduce readmissions.

Target population: The target population is our congestive heart failure (CHF) patients discharged from the hospital in need of additional case management. During SFY12 the organization discharged 585 patients with a primary diagnosis of CHF

Category 2 expected patient benefits: The project seeks create a care transition registry in DY2 and increase its size 10.5% over baseline by DY5. Over the length of the project, from DY2 – DY5, the goal is to provide services to an estimated 1,300 patients.

Category 3 outcomes: IT-3.2 our goal is to reduce the Congestive Heart Failure 30 day readmission rate from 17.1% currently to 15.39% by DY5.

Project Narrative

Project Description: Create smooth transitions of care from inpatient to outpatient settings, alternative inpatient settings (e.g., skilled nursing facilities), or home care so that patients being discharged (or responsible party, as appropriate) understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions. This expansion will be implemented using more information to better identify patients needing case management services and increased staff. The piloted approached with be aided by a tablet like product that will help selected patients better manage their weight, needed medications, vital signs, and needed appointments The expected outcome of this initiative is establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions and increase the number of identified program enrollees by ~~20%~~ 10.5%, as compared to baseline. Over the length of the project, from DY2 – DY5, the goal is to provide services to an estimated 1,300 patients. Lastly this program addresses CN.3 CN.4, and CN.6.

Starting Point/Baseline: CHRISTUS St. Michael Health System (CSM) has briefly piloted a care transition nurse who has substantial success with the patients that the one nurse has been in contact with. Compared to the CSM patient population, which has readmission rates slightly above for FY12 8%, the only transition nurse has readmission rates below 1%. Due to limited staff the use of technology will increase the patients understanding of their diagnoses, medications, and self-care needs.

Rationale: When a patient's transition from the hospital to their residence is less than optimal, the repercussions can be far-reaching: increased hospital readmission rates, feelings of poor patient experience, and even mortality. Without the patient having sufficient information and an understanding of their diagnoses, medication, and self-care needs – patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and poor associate satisfaction. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions.

Nationwide, patients leave the hospital not understanding why they were admitted, what was done for them in the hospital, and how to care for themselves once released. In particular, patients often leave not knowing what medicines they should and should not be taking, what symptoms to look out for, and who to contact for problems. This lack of knowledge frequently causes patients to be readmitted, causing needless suffering and preventable health care costs. Patients with complex social and medical problems, who represent a significant portion of CSM community members, are at particularly high risk for readmission and poor health status. The challenges of making the project successful and reducing readmissions are rooted in human interaction as a patient touched by many individuals from admission to discharge which can lead to human error when giving discharge instructions. Much of the problem stems from the use of medications and improper diet, whether a patient properly lists all medications they currently use during admission, instructions are misread due to low levels of literacy, or an individual isn't aware of the effects that their diet will have on their recovery to better health. The mobile device provided by the hospital when used to its full potential will increase the number of patients that will get intervention before a complication leads to readmission. Addressing these issues in our region are aligned with the regional goals of reducing the costs of health care, improve the health of populations, and addresses CN.3 CN.4, and CN.6

Related Category 3 Outcome Measure(s): IT-3.2 Congestive Heart Failure 30 day readmission rate 127278302.3.52 Pass 3b (127278302.3.27)

This measure estimates the hospital-level, risk-standardized rate of unplanned, Heart failure readmissions after admission for heart failure within 30 days of hospital discharge (RSRR) for patients aged 18 and older. This was chosen as the outcome measure because it is closely aligned with the purpose of which the category 2 pilot was made to effect and supported by the Institute of Health Improvement[54].This will help lower income members of the community because of the limited access to transportation and having access to a health professional will assist in their perceived level of health literacy.

[54] Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012

Interrelated projects: 127278302.2.20 Pass 3b (127278302.2.9) is related to the success of this project by creating an environment where care is coordinated and supported in an ambulatory setting.

Relationship to Other Performing Providers' Projects in the RHP: Successes and lessons learned will be shared by other RHP members through the regional learning collaborative described below.

Plan for Learning Collaborative: The RHP Region 1 anchor will sponsor meetings and conferences to facilitate the opportunity for healthcare providers throughout the region and the state to share experiences, challenges, lessons learned and best practices. The leadership team for this project will actively participate in those opportunities.

Project Valuation: This project addresses significant priority regional needs (CN.3 CN.4, CN.6) as a big problem, it requires an investment of additional staff, training, and tablets (for some patients who would be best served by its use) to adequately demonstrate effectiveness of transforming the healthcare delivery system. Specific outcomes that CSM is pursuing as a result of effectively implementing this project that have financial value to the region and organization are a reduction in chronic patient readmissions, reduction in preventable emergency department visits, and better care management of our most vulnerable patients.

127278302.2.22 Pass 3b (127278302.2.11)	***2.12.2***	***N/A***	***Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population***	
UPA				*127278302*
Related Category 3 Outcome Measure(s):	127278302.3.52 Pass 3b (127278302.3.27)	*3.IT-3.2*	*Congestive Heart Failure 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: *Implement standardized care transition processes* Metric 1 [P-2.1]: Care transitions policies and procedures Baseline/Goal: Submission of protocols Data Source: Policies and procedures of care transitions program materials **Milestone 1** Estimated Incentive Payment (*maximum amount)*: $1,463,842	**Milestone 2** [I-13]: Increase the number or percent of patients in the case management related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case management related registry; patients may be targeted from ED and inpatient areas Baseline/Goal: Increase percentage of patients served by 5% over DY2 baseline. Data Source: EHR, claims, registry or other program documents **Milestone 2** Estimated Incentive Payment: $ 1,246,413		**Milestone 3** [I-13]: Increase the number or percent of patients in the case management related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case management related registry; patients may be targeted from ED and inpatient areas Baseline/Goal: Increase percentage of patients served by 8% over DY2 baseline. Data Source: EHR, claims, registry or other program documents **Milestone 3** Estimated Incentive Payment: $1,163,514	**Milestone 4** [[I-13]: Increase the number or percent of patients in the case management related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case management related registry; patients may be targeted from ED and inpatient areas Baseline/Goal: Increase percentage of patients served by 10.5% over DY2 baseline. Data Source: EHR, claims, registry or other program documents **Milestone 4** Estimated Incentive Payment: $ 991,234
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,463,842	Year 3 Estimated Milestone Bundle Amount: $1,246,413		Year 4 Estimated Milestone Bundle Amount: $1,163,514	Year 5 Estimated Milestone Bundle Amount: $991,234
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $4,865,003				

Project Option: 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population
Unique RHP Project ID: 127278302.2.23 Pass 3b (127278302.2.12) (Pass 2)
Performing Provider Name/TPI: University Physician Associates/127278302

Project Abstract

Provider Description: This project is a collaboration of University Physician Associates with the executing provider Palestine Regional Medical Center, a 156 bed hospital that serves approximately 100,000 people including Palestine/Anderson County and surrounding communities (approximately 1,000 square miles). A full range of comprehensive care is offered including the latest in diagnostic, therapeutic and rehabilitative services on both an inpatient and outpatient basis. Healthcare services include Acute Care, Behavioral Health Services, Cardiac Care, Diagnostic Imaging, Emergency Services, Intensive Care, Interventional Cardiology, Obstetrics and Gynecology, Rehabilitation, Sleep Medicine, Surgery and Wound Care..

Intervention(s): This project will provide an Intensive Outpatient Program for adult behavioral health. Patients will be referred to the program at discharge from the inpatient setting, directly from the ER setting, from the crisis stabilization (DSRIP Project # 127278302.1.13 Pass 3b (127278302.1.7)) unit, or from other sources, when the patient does not meet inpatient criteria. Substance abuse counseling is a component of this program. The overall goal is to avoid acute crisis situations by getting the patients into the appropriate setting for the appropriate level of care to decrease unnecessary ED visits, admissions and readmissions.

Need for the Project: In 2012, over 523 patients were admitted to the adult inpatient unit, 78 (14.7%) of the patients readmitted to the inpatient program within 30 days of discharge. The average length of stay is 5.2 days for each admission. Most patients have no follow-up resource at discharge thus return to the ER as their primary source of care. The county currently sends prisoners to Huntsville (100 miles) for assessment. There is no behavioral health outpatient program in this area, it is hard to estimate the number of patients who will benefit. The behavioral health patient to mental health professional ratio in Anderson County is 5155:1 with an estimated 1 in 17 (>3,400) residents suffering from a mental illness (University of Wisconsin Population Health Institute, *2012 County Health Rankings*).

Target Population: 225 patients (43%) of patients admitted to the inpatient behavioral health services are Medicaid eligible, many have no funding source; they will benefit from an outpatient therapy program as part of a post-acute care program. 440 additional patients did not meet inpatient criteria and were not admitted as an inpatient. The anticipated Medicaid/indigent benefit of a intensive outpatient program is to provide those patients an alternative treatment option to the stress of emergency departments and/or inpatient psychiatric services.

Category 2 Expended Patient Benefits: Based on the projected staffing model to be used during the demonstration period, we anticipate an approximate monthly admission rate of 8 patients to the intensive outpatient program beginning in DY3. This project seeks to increase utilization of the Intensive Outpatient Program over the projected baseline established in DY3 start up by 5% in DY4

and 10% in DY5. Intensive outpatient program participants will engage in 6 hours of group therapy per week (2 hours per day – 3 days per week) with a projected average length of stay in the program of 8-16 weeks.

Category 3 Outcomes: As a demonstration project, our goal is to reduce emergency room visits for behavioral health patients and provide improved continuum of care for patients discharged from inpatient services and/or crisis stabilization. Based on our recent emergency department activity with behavioral health inpatient admissions, we expect to reduce ER visits for behavioral health patients who have completed inpatient and/or crisis stabilization services within 30 days of discharge by 96 patient visits per year in DY3 with additional decrease by 5% in DY4 and 10% by DY5 compared with projected DY3 established baseline.

Project Narrative

Project Description:

Develop an intensive outpatient behavioral health therapy program to continue care for adult behavioral health patients after completing the existing inpatient programs or for patients leaving the crisis stabilization (DSRIP Project #127278302.1.13 Pass 3b (127278302.1.7)) unit that do not meet inpatient criteria and patients requiring behavioral health therapy in order to avoid crisis situations.

The Intensive Outpatient Program will work with behavioral health patients individually to develop the most appropriate treatment plan to meet their needs. Individual, group and family counseling services will be offered for behavioral health issues and substance abuse counseling. Intensive outpatient program participants will engage in 6 hours of group therapy per week (2 hours per day – 3 days per week) with a projected average length of stay in the program of 8-16 weeks.

Goal(s) and relationship to Regional goal(s):

Project goals: Promote better health outcomes for behavioral health patients. Decrease unnecessary ED visits. Decrease unnecessary admissions and readmissions.

This project addresses the RHP's **regional goal** of addressing shortages in behavioral health care services, which is a key health challenge in the community needs assessment for Region 1. Furthermore, this project will prevent unnecessary hospitalizations, which is also a key challenge in the community needs assessment **CN.4** (high costs due to potentially preventable hospitalizations) and **CN.5** (inappropriate use of emergency department utilization).

Challenges:

The challenges of the current programs available in Region 1 include:

- Inadequate behavioral health service programs
- Lack of substance dependency/abuse services
- Lack of transportation assistance due to extensive rural environment.
- Lack of behavioral health resources for judicial and law enforcement entities

Thus behavioral health patients only receive medical treatment when in a crisis situation resulting in increased loads in area emergency departments, excessive use of ICU or acute care services and draining local law enforcement agencies and judicial systems with behavioral health patients ending up in the judicial system rather than appropriate treatment programs. A potential

challenge to implementing this project as planned is changing the referral and continuity of care process for patients who have behavioral health needs. This will be addressed by conducting training for health care and law enforcement staff to enhance the awareness and understanding of procedures to assure the person needing services is seen in the right place, at the right time , by the right provider.

5-year expected outcome for provider and patients:

It is the goal of the program to improve continuity of care for area residents, decrease readmissions to inpatient programs and decrease emergency room visits. The Department of State Health Services estimates that over 85,000 individuals in Region 1 have a serious mental illness, with well over 100,000 needing treatment for alcohol/drug use. According to the National Institute of Mental Health, National Institutes of Health, in 2005 the estimated Anderson County population needing but not receiving treatment for alcohol use was 1 in 17 (3,417 people) and for illicit drug use it was 1 in 51.

As a demonstration project, our goal is to reduce emergency room visits for behavioral health patients and provide improved continuum of care for patients discharged from inpatient services and/or crisis stabilization. Based on our recent emergency department activity with behavioral health inpatient admissions, we expect to reduce ER visits for behavioral health patients who have completed inpatient and/or crisis stabilization services within 30 days of discharge by 96 patient visits per year in DY3 with additional decrease by 5% in DY4 and 10% by DY5 compared with projected DY3 established baseline.

Starting Point/Baseline:

PRMC does not have an intensive outpatient behavioral health program. Therefore, the baseline data for all metrics will be set to 0. Time period for baseline: 6/30/12

Rationale:

Palestine Regional Medical Center Rehabilitation Center is a 100,000 square foot facility that currently is only being used at a 33% capacity including the operating behavioral health inpatient services for both adult and geriatric inpatient programs. We also currently have an intensive outpatient program for geriatric patients (age 55 and older). Therefore, this facility has the infrastructure available to expand the outpatient services area to include the proposed adult intensive outpatient program with renovations to existing infrastructure. PRMC has one board certified psychiatrist and one dual certified psychiatric neurologist. Having a psychiatric neurologist on staff will allow comprehensive treatments that will examine and address the physical and psychological components of a crisis patient's illness, thus getting them to appropriate treatment programs (physical or psychological) more quickly. Also this outpatient program would work hand in hand with the proposed crisis stabilization services (DSRIP RHP Project #127278302.1.13 Pass 3b (127278302.1.7)).

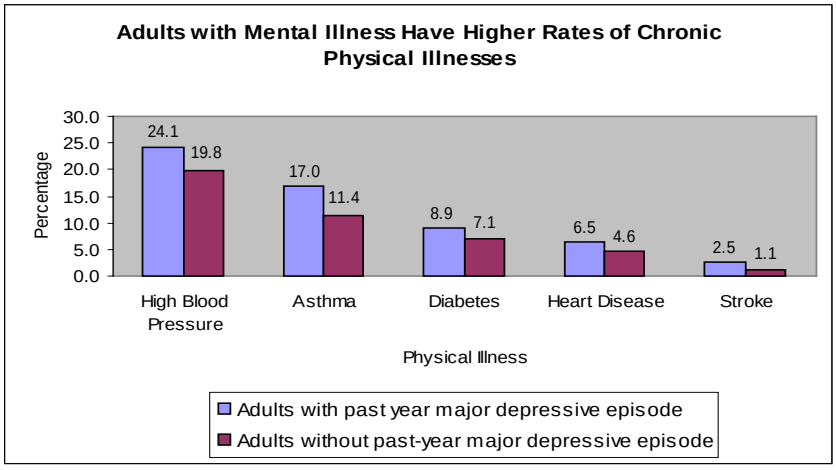
In addition to the crisis stabilization unit, support services will include a Behavioral Health Assessment Team (BHAT), crisis hotline number and dispatch services for assessments, consultations and transportation services. Development of appropriate outpatient services will be provided in collaboration with Anderson Cherokee Counties Enrichment Services (ACCESS), our local mental health authority, in order to enhance both existing and new services. Outpatient counseling services will include individual treatment planning, chemical/substance abuse

education, physical therapy/exercise, life management and coping skills, nutritional counseling, alternative therapy (music, activities, relaxation, etc) and family education/counseling.

Over 523 patients have been admitted to the adult inpatient unit with 14.7% of patients have readmitted into the program within 30 days of discharge of initial admission. With an intensive outpatient program the number of readmissions could be drastically reduced thus reducing costs for the hospitals and LMHA and with substance abuse counseling programs reduce costs for local law enforcement and judicial systems.

Currently in this southern area of Region 1 the only access to behavioral health outpatient therapy is the limited services of the local mental health authorities and private practice services; none of which have programs or assistance for substance abuse issues. A behavioral intensive outpatient program would not only benefit the community wellness, it would significantly decrease costs for local hospitals, LMHAs and law enforcement agencies. By combining agency partnerships with development of new outpatient programs behavioral health patients will experience continued counseling services resulting in more timely and effective treatment interventions as well as fewer crisis situations requiring ER or law enforcement interventions and readmissions into behavioral health inpatient programs.

Statistics also show that adults with mental illness have higher rates of chronic physical illnesses and are more likely to be treated in emergency departments and subsequently hospitalized.[1]



Program outcomes will be based on standardized quantitative measures and qualitative analysis relevant to the defined target populations of the region.

Project components:

a) Assess size, characteristics and needs of target population(s)
b) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.
c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
d) Design models which include an appropriate range of community-based services and residential supports.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

Milestones & Metrics:

The milestone and metrics selected were chosen to establish a system to best deliver crisis stabilization services to a currently underserved population ultimately reducing costs for area hospitals and EDs, judicial systems, etc. These milestones will ensure achievement DSRIP goals of continuous quality improvement and collaborative learning in effort to achieve higher level of performance and outcomes within the 5 years of the program.

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[1] *Physical Health Conditions among Adults with Mental Illnesses* report based on Substance Abuse and Mental Health Services Administration (SAMHSA) 2008-2009 National Survey on Drug Use and Health (NSDUH) data

Unique community need identification number the project addresses:

CN.1 – Insufficient access to primary and specialty health care services

CN.2 – Insufficient access to mental and behavioral health services.

CN.3 – High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.

CN.5 – Inappropriate emergency department utilization.

Palestine Regional Medical Center statistics show 170 behavioral health patients in 2011 spent days in the ICU for a total cost of $700,000 annually and an additional $450,000 ER visits and waiting times. If crisis stabilization services had been available, significant costs savings would have resulted. Crisis stabilization services within the southern area of this region would significantly and positively impact the entire region by expanding services offered to an underserved population.

PRMC owns a 100,000 square foot facility that currently is only being used at a 33% capacity including the operating behavioral health inpatient services for both adult and geriatric inpatient programs and geriatric intensive outpatient program. This facility already has the infrastructure available to add a secure 10 bed crisis stabilization unit with minor modifications and upgrades. In addition to the crisis stabilization unit, support services will include a Behavioral Health Assessment Team (BHAT), crisis hotline number and dispatch services for assessments, consultations and transportation services. Outpatient counseling services will include individual treatment planning, chemical/substance abuse education, physical therapy/exercise, life management and coping skills, nutritional counseling, alternative therapy (music, activities, relaxation, etc) and family education/counseling.

Related Category 3 Outcome Measure(s):

IT-9.2 Appropriate ED Utilization

According to a News and Numbers report from the Agency for Healthcare Research and Quality (AHRQ), nearly 12 million visits made to U.S. hospital emergency departments in 2007 involved people with a mental disorder, substance abuse problem or both.

This accounts for 1 in 8 of the 95 million visits to EDs by adults that year.[2] Palestine Regional Medical Center statistics show 170 behavioral health patients in 2011 spent days in the ICU for a total cost of $700,000 annually and an additional $450,000 ER visits and waiting times.

Chronicle illness data relating to selected Category 3 outcomes are described above and is identified as a community need by the RHP. The primary goal of this outcome measure is to achieve a more appropriate utilization of the ED by reducing the number of services that would have more appropriately been delivered at an alternate site of care (intensive outpatient services or crisis stabilization unit). The ED appropriate Utilization improvement target will measure the true impact the linked intensive outpatient behavioral health project is having on ED utilization. The anticipated Medicaid/indigent benefit of an intensive outpatient program is to provide those patients an alternative treatment option to the stress of emergency departments and/or inpatient psychiatric services.

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[2] AHRQ News and Numbers is based on data in Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007

Relationship to Other Projects:

Telemedicine services program (DSRIP 127278302.1.13 Pass 3b (127278302.1.7)) being proposed by University Physicians Associates will work hand-in-hand with the crisis stabilization services and intensive outpatient services to improve delivery of behavioral health services to area patients.

Relationship to Other Performing Providers' Projects in the RHP:

This project will lay a foundation for, and reinforce the clinical effectiveness of, other DSRIP projects such as:

1.10 Enhance Performance Improvement and Reporting Capacity
2.2 Expand Chronic Care Management Models
2.4 Redesign to Improve Patient Experience
2.5 Redesign for Cost Containment

Plan for Learning Collaborative:

Palestine Regional Medical Center plans to collaborate with UT Health Science Center Tyler, local mental health authorities, law enforcement/judicial agencies and other providers within the region with intensive outpatient programs. Participation in learning collaborative efforts will encourage alliances across the region by allowing providers to share lessons learned, challenges faced and develop best practices that will ultimately benefit recipients of the services provided.

Project Valuation:

In valuing this project, PRMC took into account the extent to which the implementation of an intensive outpatient behavioral health program would provide cost avoidance with reduced readmissions to inpatient behavioral health programs/hospital admissions. Patients receiving continued counseling and therapy services offered through an intensive outpatient program are less likely to suffer an acute behavioral health crisis; this will **prevent** the need for ED/acute care services and/or judicial intervention. Ongoing rather than acute care will thus reduce excessive ED costs, reduce demand (costs) for local law enforcement involvement, reduce demand (cost) to judicial organizations and thereby increase the **efficient allocation of resources** in Region 1. Furthermore, the program will add a much needed component to the healthcare infrastructure in the community, thus meeting one of the three main goals of the waiver.

127278302.2.23 Pass 3b (127278302.2.12)	***2.13.1 A-E***		***DESIGN, IMPLEMENT, AND EVALUATE RESEARCH-SUPPORTED AND EVIDENCE-BASED INTERVENTIONS TAILORED TOWARDS INDIVIDUALS IN THE TARGET POPULATION***
University Physician Associates			*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.53 Pass 3b (127278302.3.30)*	*3.IT-9.2*	*ED appropriate utilization*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric 1 P-1.1 Baseline/Goal: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization a. Data source: Project documentation; Inpatient, discharge and ED records, State psychiatric facility records, survey of stakeholders (inpatient providers, mental health providers, social services, and forensics); literature review. Milestone 1 Estimated Incentive Payment (Max amount): **$367,964**	**Milestone 2** P-3: Enroll and serve individuals with targeted complex needs (e.g. a diagnosis of severe mental illness with concomitant circumstances such as cognitive issues resulting from severe mental illness, forensic involvement resulting in extended or repeated inpatient psychiatric facilities) Metric 1 P-3.1 Baseline/Goal: Number of targeted individuals enrolled/served in the project a. Data source: Project documentation Milestone 2 Estimated Incentive Payment (Max amount): **$378,077**	**Milestone 3** P-6: Review project data and respond to it every quarter with test of new ideas, practices, tools or solutions. This data should be collected with simple interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 1 P-6.1 Baseline/Goal: Number of new ideas, practices, tools or solutions tested by each provider. a. Data source: Brief description of the idea, practice, tool or solution tested by each provider each quarter. b. Rationale/Evidence: The rate of testing of new solutions and ideas is one of the greatest predictors of the success of a health care system's improvement efforts. Milestone 3 Estimated Incentive Payment (Max amount): **$189,588.25** **Milestone 4** I-4.1: Anti-depressant medication management over six months for Major Depressive Disorder and anti-depressant medication during acute phase over 12 weeks (NQF# 0105) Metric 1 I-4.1:~~Increase by **5%** the~~	**Milestone 5** I-4.1: Anti-depressant medication management over six months for Major Depressive Disorder and anti-depressant medication during acute phase over 12 weeks (NQF# 0105) Metric 1 I-4.1 ~~Increase by **10%** the percentage of individuals with schizophrenia receiving the specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the measurement period (12 consecutive months)~~ ~~a. Numerator: The percentage of individuals with schizophrenia who filled at least two prescriptions for an antipsychotic and had a PDC for antipsychotic medication that is greater than or equal to 0.8.~~ ~~b. Denominator: The number of individuals at the end of the measurement period with schizophrenia with at least two claims for an antipsychotic during the measurement period.~~ ~~c. This would be measured at specified time intervals~~

127278302.2.23 Pass 3b (127278302.2.12)	***2.13.1 A-E***		***DESIGN, IMPLEMENT, AND EVALUATE RESEARCH-SUPPORTED AND EVIDENCE-BASED INTERVENTIONS TAILORED TOWARDS INDIVIDUALS IN THE TARGET POPULATION***	
University Physician Associates				*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.53 Pass 3b (127278302.3.30)*	*3.IT-9.2*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			~~percentage of individuals with schizophrenia receiving the specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the measurement period (12 consecutive months)~~ ~~a. Numerator: The percentage of individuals with schizophrenia who filled at least two prescriptions for an antipsychotic and had a PDC for antipsychotic medication that is greater than or equal to 0.8.~~ ~~b. Denominator: The number of individuals at the end of the measurement period with schizophrenia with at least two claims for an antipsychotic during the measurement period.~~ ~~c. This would be measured at specified time intervals throughout the project to determine if there was a decrease.~~ Increase by **5%** the percentage of individuals with Major Depressive Disorder receiving the specialized interventions who were diagnosed with a new episode of major	~~throughout the project to determine if there was a decrease.~~ ~~d. Data Source: Claims and Encounter Data~~ ~~e. Rationale/Evidence: NOTE: This metric is currently under review by NQF; not finalized.~~ Increase by **10%** the percentage of individuals with Major Depressive Disorder receiving the specialized interventions who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. a. Numerator: i. Effective Acute Phase Treatment: The numbers of individuals with Major Depressive Disorder receiving specialized interventions with at least 84 days (12 weeks of continuous treatment with antidepressant medication during the 114-day period following the Inpatient Service Day (IPSD) (inclusive) ii. Effective Continuation Phase Treatment: the number of individuals with Major

127278302.2.23 Pass 3b (127278302.2.12)	***2.13.1 A-E***		***DESIGN, IMPLEMENT, AND EVALUATE RESEARCH-SUPPORTED AND EVIDENCE-BASED INTERVENTIONS TAILORED TOWARDS INDIVIDUALS IN THE TARGET POPULATION***	
University Physician Associates				*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.53 Pass 3b (127278302.3.30)*	*3.IT-9.2*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. a. Numerator: i. Effective Acute Phase Treatment: The numbers of individuals with Major Depressive Disorder receiving specialized interventions with at least 84 days (12 weeks of continuous treatment with antidepressant medication during the 114-day period following the Inpatient Service Day (IPSD) (inclusive) ii. Effective Continuation Phase Treatment: the number of individuals with Major Depressive Disorder receiving specialized interventions with at least 180 days (6 months) of continuous treatment with antidepressant medications (Table AMM-D) during the 231-day period following IPSD (inclusive). b. Denominator: The number of individuals with Major Depressive Disorder receiving specialized interventions who	Depressive Disorder receiving specialized interventions with at least 180 days (6 months) of continuous treatment with antidepressant medications (Table AMM-D) during the 231-day period following IPSD (inclusive). b. Denominator: The number of individuals with Major Depressive Disorder receiving specialized interventions who are diagnosed with a New Episode of major depression and treated with antidepressant medication. c. Data Source: Claims and Encounter Data d. Rationale/Evidence: See project goal Milestone 4 Estimated Incentive Payment (Max amount): **$313,233**

127278302.2.23 Pass 3b (127278302.2.12)	***2.13.1 A-E***		***DESIGN, IMPLEMENT, AND EVALUATE RESEARCH-SUPPORTED AND EVIDENCE-BASED INTERVENTIONS TAILORED TOWARDS INDIVIDUALS IN THE TARGET POPULATION***	
University Physician Associates				*127278302*
Related Category 3 Outcome Measure(s):	*127278302.3.53 Pass 3b (127278302.3.30)*	*3.IT-9.2*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			are diagnosed with a New Episode of major depression and treated with antidepressant medication. c. Data Source: Claims and Encounter Data d. Rationale/Evidence: See project goal Milestone 4 Estimated Incentive Payment (Max amount): **$189,588.25**	
Year 2 Estimated Milestone Bundle Amount: **$367,964**	Year 3 Estimated Milestone Bundle Amount: **$378,077**		Year 4 Estimated Milestone Bundle Amount: **$379,177**	Year 5 Estimated Milestone Bundle Amount: **$313,233**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: **$1,438,451**				

Project Option 2.7.5 - Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents
Unique Project Identifier Number: 127278302.2.13 (PASS 3)
Performing Provider/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Project Abstract

Provider Description: UTHSCT – MSRDP (University Physician Associates). UTHSCT is a hospital in Tyler TX with 6 satellite clinics serving Region 1 and a satellite office at Paris Regional Medical Center in Paris TX. The Paris/Lamar County office has been used primarily for research since 2010 and health promotion since 2012.

Intervention: This project will extend the evidence based, multi-disciplinary pediatric weight management program from the Center for Obesity and its Complications on Health (COACH) at Children's Medical Center in Dallas to a rural county in Northeast Texas (Lamar; County Seat = Paris, TX).

Need for the Project: Approximately 4,000 children between the ages of 6-18 living in Lamar County Texas are overweight or obese and therefore at risk for diabetes, fatty liver, high blood pressure, high cholesterol, and premature death. Lamar County has no comprehensive, evidence based pediatric weight management program available to serve this population.

Target Population: The target population is children age 6-18 residing in Lamar County with a BMI > 85th percentile and a caregiver willing and available to attend a 12-week course and initiate behavior changes conducive to maintaining a healthy body weight. Although 4,000 children meet the BMI requirements, only 75 patients per year are expected to complete the program by Year 5 because lifestyle changes are so difficult to implement. Most patients are expected to have Medicaid, as 78% of births are Medicaid in Lamar County.[1]

Category 2 Expected Patient Benefits: The attrition rate for pediatric weight management programs is about 50% as a national average. The project seeks to enroll 80/retain 40 children in DY3; enroll 120/retain 60 in DY4; and enroll 150/retain 75 in DY5. Patients who complete the program are expected to have a lower BMI and better quality of life.

Category 3 Outcomes: IT-10.1, Our goal is to improve quality of life scores on the PedsQL by 5% for those who complete the weight management program.

1. Texas DSHS County Health Profiles, http://www.dshs.state.tx.us/chs/cfs/2008/2008-Health-Facts-Profiles-for-Texas/, accessed 12/10/12

Project Narrative

Project Description: The increasing prevalence of obesity in children and adolescents is one of the most pressing challenges facing today's society. Because of obesity, this generation of

children is expected to be the first generation with a shorter life expectancy than their parents. The economic costs of obesity are staggering, rising from about $39 billion in 1986 to $147 billion in 2006[1] (Harvard 2012). Fortunately, lifestyle interventions involving a combination of diet, exercise, and behavior modification are effective in reducing pediatric obesity[2] (Ho, et.al 2012).

The main goal of this project is to make a state-of-the-art, multi-disciplinary pediatric weight management program available to families in rural Lamar County Texas. The Center for Obesity and its Complications on Health (COACH) at Children's Medical Center in Dallas, Texas offers comprehensive dietary and behavioral treatment for obese children with excellent results. No centers or programs of this nature exist in rural Northeast Texas. The infrastructure exists, however, to establish a satellite weight management clinic in Paris to serve both Paris and Lamar County. UT Southwestern, the academic home for Children's Hospital faculty, and UT Health Sciences Center Tyler began working together in 2008 to implement the National Children's Study in Lamar County, TX. Recruitment for the Study has ended, but study personnel have started work on a new project funded by the Centers for Disease Control and have the capacity to add another new project on pediatric weight management.

Goal:

The overall **goal** of this project is to facilitate healthier lifestyles in children who are diagnosed as overweight or obese, leading to healthier BMIs (body mass index). After an initial evaluation in Dallas, the children and their caregivers will enroll in a 12-week course to address healthy eating and active living. A local coordinator in Paris will lead the classes and serve as a health coach for participants with supervision and guidance from the COACH staff.

Challenges and Solutions:

A challenge to the implementation of this project will be to establish a high quality satellite without the resources of the Dallas Center. Technology can help with sharing of resources. For instance, Children's uses the EPIC electronic medical record, which can be accessed using almost any web browser. UTHSCT has already established a highly secure, FISMA compliant VPN at the Paris satellite office that is suitable for secure communications, including a shared electronic medical record. Fewer exercise programs are available in Paris than in Dallas; however, those that are available are highly visible and accessible due to the small town environment. For instance, a beautiful walking trail (the Trail de Paris) runs behind the only pediatrics clinic in Paris, past the only college (Paris Junior College), and near several Paris schools. The city offers Jazzercise classes, parks, and sports leagues. Establishing logistics for the program will be challenging. For instance, billing and collection would ideally reside with COACH in Dallas, but the administrative team will have to determine how Medicaid wants to handle billing for a satellite program. The Paris team will need to establish mechanisms for accepting referrals and communicating with providers. All the Paris pediatricians work together in one group practice, which facilitates communication. In fact, the UTHSCT team has been working with the pediatrician group for several years already to implement the Children's Study and has established collegial working relationships.

Starting Point/Baseline:

At the current time (December 2012), there is no pediatric weight management program in Lamar County, where Paris is the County Seat. The racial/ethnic composition is about 79% white, 4% Hispanic, and 15% black[3]. Lamar County has about 8,823 children between the ages of 5 – 17[4]. The childhood obesity prevalence rate in Texas is about 23% for elementary children and 19% for high school children[5], which means about 1,943 children are obese. The definition of "obese" is a body mass index > the 95th percentile, and "overweight" means a body mass index > the 85th percentile but less than the 95th percentile on the standard growth charts. The prevalence of overweight is about the same as the prevalence of obese; therefore, about 4,000 children in Lamar County are overweight or obese and in need of the proposed program. Most families who need the program are not willing to make the substantial effort to completely change their lifestyles; therefore, enrollment and retention tends to be only a fraction of the eligible population.

The performing provider obtained additional data from the pediatric group practice in Paris TX. In a **one-month** period in 2012, the 6-pediatrician group saw 116 children ages 6-18 who were overweight and 193 children who were obese, for a total of 309 who would qualify for the proposed weight management program based on weight[6]. We will meet our target enrollment If only 2-3% of these children enroll in the weight management program.

Expected Outcome by the conclusion of the project in DY5:

The expected outcome at the conclusion of this project in DY5 is that a comprehensive, sustainable pediatric weight management program will be established in Lamar County, TX, a rural county where no such program has ever existed. Children are expected to enjoy a better quality of life as a result of this program, including being more active, more confident, and more sociable as measured in the PedsQL survey.

Rationale:

Addresses regional goals: This project is designed to meet **Community Need (CN.3)**, high rates of chronic disease, including asthma, obesity, and cancer.

Childhood obesity has many intermediate and **long-term health consequences**. Overweight children and adolescents are more likely to become obese as adults. Obesity is a risk factor for a variety of chronic conditions, including type 2 diabetes, hypertension, high cholesterol, stroke, heart disease, nonalcoholic fatty liver disease, certain cancers, arthritis, and overall higher mortality. Other health consequences of childhood obesity include eating disorders and mental health issues such as depression and low self-esteem.[7]

Pediatric weight management is challenging. A large number of biological, behavioral, social, environmental and economic factors and the complex interactions between them promote a positive energy balance for many. Multiple, comprehensive interventions are needed to fight the growing obesity epidemic. Clinical weight management programs are part of the solution. Key components include intensive nutrition counseling, physical activities that children enjoy, behavioral modification, and involvement of the entire family.[8]

Comprehensive pediatric weight management programs are inaccessible to most residents of rural areas. The innovative aspect of the proposed program is to bring such a program to a rural area using a coordinator in a small satellite office. Technology such as a shared electronic medical record, shared meeting platforms such as "Go to Meeting", and

electronic tools for weight management make satellite operations more feasible than in the past.

The proposed program will fully develop the plan for operating a COACH satellite program (milestone P-1), implement the plan (milestone P-2), and increase access in a rural population that otherwise has no pediatric weight management program (milestone I-7). Only a small percentage of the approximately 4,000 children in Lamar County who are overweight or obese will have the motivation and tenacity to complete the program. Nonetheless, a few participants will be a large increase over the 0 patients who currently participate in a pediatric weight management program in Lamar County (milestone I-7).

Related Category 3 Outcome Measure(s):

In DY3 – 5, a standalone measure is selected from OD- 10 Quality of Life/ Functional Status, IT 10.1 Quality of Life. Through the use of Pediatric Quality of Life Inventory (PedsQL), the impact of a comprehensive weight management program will be measured based upon key psychosocial domains in a widely used, valid, reliable instrument.

Relationship to Other Projects:

The pediatric obesity program is unique to UPA; however, some of the marketing approaches for the colorectal cancer screening program (127278302.2.5) can be shared. In addition, the asthma van (127278302.2.15 Pass 3b (127278302.2.3 **(**Pass 1)) targeting the pediatric population might have some synergy with the obesity program. For instance, the Live Well Colorado Get Movin' Mobile Van brings fun physical activities to children where they live. The "mobile unit" concept could have application for pediatric obesity treatment.

Relationship to Other Performing Providers' Projects in the RHP:

The pediatric obesity program is unique in this RHP. However, some of the

Plan for Learning Collaborative:

The University of Texas Health Science Center at Tyler (UTHSCT) houses The Northeast Texas Center for Rural Community Health (The Center). The Center will serve as a convener of external and internal partners to share DSRIP project implementation and lessons learned. It will serve as the clearing house for best practices and regional data transmission through the process of implementation of DSRIP projects.

Project Valuation:

The per capita cost of obesity is estimated to be about $2000 per year (Harvard 2012). If only 50 children adopt a healthier lifestyle leading to 60 years of normal body weight, the total savings to the health care system would be about $6 million.
The project will fill a gap in a rural area that currently does not have a comprehensive pediatric weight management program.

References:

1. The Obesity Prevention Source, Harvard School of Public Health, accessed 12/11/12. http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/economic/
2. Ho, et.al. Effectiveness of Lifestyle Interventions in Child Obesity: Systematic Review with Meta-analysis, Pediatrics 2012; 130; e1647
3. Texas County Health Profiles, Texas DSHS. http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc; accessed 12/11/12
4. U.S. Census Bureau, S0101; AGE AND SEX, Lamar County Texas 2009-2011 American Community Survey 3-Year Estimates (http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_3YR_S0101&prodType=table); accessed 12/11/12
5. Prevalence of Overweight and Obese among Children in Texas between 2004 and 2005. (Source: Hoelscher DM, Perez A., Lee ES, Sanders J, Kelder SH, Day RS, Ward J. School Physical Activity and Nutrition (SPAN) III Survey, 2004-2005. UT School of Public Health, Houston) (www.dshs.state.tx.us/obesity/pdf/TxObesityData.doc); accessed 12/10/12
6. Custom report from eclinical electronic medical record, Primary Care Associates, Paris TX, 12/10/12 (available on request)
7. AHRQ Research Protocol for Childhood Obesity Prevention Programs: A Comparative Effectiveness Review and Meta-Analysis, protocol published 12/20/11. http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=902&pageaction=displayproduct; accessed 12/10/12
8. US Preventive Services Task Force. Screening and Interventions for Childhood Obesity, July 2011 (http://www.uspreventiveservicestaskforce.org/uspstf05/choverwt/choversum.htm#Conclusions)

127278302.2.13	2.7.5	2.7.5	Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents	
University Physician Associates				127278302
Related Category 3 Outcome Measure(s):	127278302.3.31	IT-10.1	Outcome Domain – IT-10.1 Quality of Life	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Development of innovative evidence-based project for targeted population. Metric 1 P-1.1: Document innovational strategy and plan Baseline/Goal: Recruit and hire Paris coordinator; Multiple planning meetings with COACH in Dallas; Training for Paris coordinator in Dallas; Establish Paris pediatrician advisor; Begin marketing local program; Establish obesity registry within pediatrician electronic medical record; Hold focus group with eligible PCA patients to discuss readiness to change and barriers to participation; Set up IT infrastructure to maximize efficiency and communications Data Source: Documentation of meetings, training logs and implementation plan Milestone 1 Estimated Incentive Payment (*maximum amount)*: $194,162		**Milestone 2** P-2: Implement evidence-based innovational project for targeted population Metric 1 P-2.1 Document implementation strategy and testing outcomes. Baseline/Goal: Measure enrollment and retention (goal is to enroll 80 and retain 40 in first year of program); Monitor BMI (goal is to maintain or reduce BMI by the end of 12 weeks) Data Source: Electronic medical record from PCP (local pediatrician group) and/or COACH – Dallas and/or program participation log Milestone 2 Estimated Incentive Payment: $218,111	**Milestone 3** I-7: Increase access to disease prevention programs I-7.1. Metric: Increase percentage of target population reached. a. Numerator: Number of individuals enrolled in weight management program b. Denominator: Number of eligible patients from Paris pediatrics practice with the following variables: Overweight or Obese; +/- Expressed interest in program, +/- Completed application form, +/- Qualified including "ready to change" c. Data Source: PCA electronic medical record, screening tool/application form, enrollment records from weight mgmt. program Milestone 3 Estimated Incentive Payment: $211,299	**Milestone 4** I-7: Increase access to disease prevention programs using innovative project option. Metric 1 I-7.2: Increase number of program participants Goal: Increase number of participants by percent TBD over DY4 Data Source: Documentation of schedule and patient logs Milestone 4 Estimated Incentive Payment: $190,838 Estimated target for this project: enroll 350 / retain 175 through DY 5.
Year 2 Estimated Milestone Bundle Amount: $194,162		Year 3 Estimated Milestone Bundle Amount: $218,111	Year 4 Estimated Milestone Bundle Amount: $211,299	Year 5 Estimated Milestone Bundle Amount: $190,838
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ 814,410				

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 130612806.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Jacksonville 130612806

Project Abstract

Provider: East Texas Medical Center Jacksonville (ETMC) is a 74-bed, full-service hospital dedicated to serving the Cherokee County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Cherokee County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 242,000.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-reviewed healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 1,095 new primary care clinic patients each year with a Medicaid and indigent share of at least 30%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 1,643 patients. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 13,965 emergency room visits in 2012—including 10,950 non-urgent visits (78.4%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Jacksonville		
Level of Care	**ED Visits**	**Percent**
Unknown	3	0.0%
1 Resuscitation	25	0.2%
2 Emergent	213	1.5%
3 Urgent	2,774	19.9%
4 Semi Urgent	4,498	32.2%
5 Non Urgent	6,452	46.2%
Grand Total	**13,965**	**100.0%**
Percent Non-Urgent	10,950	78.4%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-reviewed healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (130612806.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (130612806.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (130612806.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease

avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $865,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $493,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		10,950
% Clinic Appropriate		15%
Clinic Appropriate Patients		1,643
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**1,109,328**
Clinic Payment @ 78% savings	$	244,052
Total Estimated Savings	**$**	**865,276**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

130612806.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Jacksonville			*130612806*
Related Category 3 Outcome Measure(s):	***130612806.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $387,932	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [548] out of a baseline of 10,950 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $423,213	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [1,095] out of a baseline of 10,950 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $424,443	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 15% [1,643]out of a baseline of 10,950 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $350,627
Year 2 Estimated Total DSRIP: $387,932	Year 3 Estimated Total DSRIP: $423,213	Year 4 Estimated Total DSRIP: $424,443	Year 5 Estimated Total DSRIP: $350,627
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,586,215***			

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 130862905.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Clarksville 130862905

Project Abstract

Provider: East Texas Medical Center Clarksville (ETMC) is a 36-bed, full-service hospital dedicated to serving the Red River County area with advanced diagnostics, medical and surgical care, and outpatient services. ETMC's primary service area is Red River County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 120,272.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 417 new primary care clinic patients each year with a Medicaid and indigent share of at least 20%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 626 patients. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 15% of non-urgent emergency room patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent

patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 5,889 emergency room visits in 2012—including 4,176 non-urgent visits (70.9%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Clarksville		
Level of Care	**ED Visits**	**Percent**
Unknown	2	0.0%
1 Resuscitation	6	0.1%
2 Emergent	171	2.9%
3 Urgent	1,534	26.0%
4 Semi Urgent	2,862	48.6%
5 Non Urgent	1,314	22.3%
Grand Total	**5,889**	**100.0%**
Percent Non-Urgent	4,176	70.9%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care

expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (130862905.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (130862905.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (130862905.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been

treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $329,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $265,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		4,176
% Clinic Appropriate		15%
Clinic Appropriate Patients		626
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**423,064**
Clinic Payment @ 78% savings	$	93,074
Total Estimated Savings	**$**	**329,990**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

130862905.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Clarksville			*130862905*
Related Category 3 Outcome Measure(s):	***130862905.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $209,194	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [209] out of a baseline of 4,176 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $228,219	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [418] out of a baseline of 4,176 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $228,883	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 15% [626] out of a baseline of 4,176 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $189,077
Year 2 Estimated Total DSRIP: $209,194	Year 3 Estimated Total DSRIP: $228,219	Year 4 Estimated Total DSRIP: $228,883	Year 5 Estimated Total DSRIP: $189,077

TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$855,372***

Project Option 2.5.3-Implement an Innovative and Evidence-Based Intervention That Will Lead to Cost Savings for Providers That Have Demonstrated Need or Unsatisfactory Performance in this Area.
Unique Project ID: 131037704.2.1 (Pass 1)
Performing Provider Name/TPI: Hopkins County Memorial Hospital 131037704

Project Abstract

Provider Description: Hopkins County Memorial hospital is a 96 bed acute hospital located in Sulphur Springs with an estimated population of 18,000 and is the only hospital provider serving Hopkins County which has a population of approximately 30,000.
Intervention(s): This project will implement a cost accounting system to identify unique and specific costs of providing care for the top 25 DRGs by volume.
Need for the Project: We currently do not have any cost accounting systems nor staff to implement the software. We have no existing methodology to measure any cost containment initiatives. This will be an opportunity to identify and test cost containment efforts focusing on our patients who are admitted in our top 25 DRGs. Areas that will be of interest is length of stay, medication costs and appropriate diagnostic usage.
Target Population: The target population will be the 2000 admissions in our top 25 DRGs, of these, approximately 25% are Medicaid, uninsured and underinsured patients.
Category 1 or 2 Expended Patient Benefits: Understanding our cost and establishing evidenced based care plans to reduce or eliminate cost while maintaining or providing high quality care. Once the baseline is established in DY3, the benefit will be a 3% cost reduction.
Category 3 Outcomes: IT-5.1 Our goal is to reduce the cost of care by a percentage established in DY3 of total costs for CHF patients.

Project Narrative

Project Description: This project establishes a cost accounting system for Memorial Hospital. The goal is to identify the unique and specific costs of providing care for our patients in the top 25 DRGs. For example, as indicated by CN.1, RHP 1 has a high proportion of counties where the age-adjusted mortality rates for congestive heart failure and ischemic heart disease are higher than the state rate. The Texas Department of State Health Services estimated that a region in East Texas has a 13 per cent rate of cardiovascular disease and CHF is one of our top ten diagnoses for inpatient stays. Only when the actual costs of CHF are identified can we begin to employ effective cost reduction strategies and tactics. We will use this strategy to look at all of our top 25 DRGs to reduce costs while maintaining quality care. We will measure variations in clinical practices and implement interventions based on the highest cost services according to the analysis using our cost accounting system. The challenges faced by the District include a lack of staff to implement the cost accounting system and analyze the findings. Another challenge will be engaging our medical staff to implement the findings of the analysis. This project provides us the finances to hire and train staff, employ hospitalists and a chief medical officer to drive the changes needed. The expected outcome is a reduction of cost for our top 25 DRGs in DY4 and DY5. This project focuses on the Northeast Texas Regional Healthcare Partnership goal of reducing the per capita cost of healthcare.

Starting Point/Baseline: Currently, there is no way to identify specific costs of providing care. Costs are imputed on a ratio of cost to charges (RCC). We have no one on staff that is trained in cost accounting methods and will have to hire an individual to be trained to perform this function. We will focus on high volume and high dollar admissions with the aim of reducing the cost while maintaining the quality of care standards. Once the cost accounting system is implemented in DY3, a baseline will be calculated for providing care to the admits in our top 25 DRGs with the greatest opportunity of reducing cost.

Rationale: This project option was selected in order to identify costs of high impact DRGs. We want to improve cost-effectiveness of care through improved care delivery for our patients and families through quality improvement initiatives. Currently the hospital is experiencing significant financial difficulties. Some of those difficulties are due to the fact that we are reimbursed less for many DRGs than the actual cost of providing the care. Since we cannot identify where the costs are outliers, it makes it difficult to understand and then identify how and where the costs can be addressed. We have MEDITECH software for all our clinical and financial applications and will also use MEDITECH's cost accounting system.

We have over 2000 admits in our top 25 DRGs and want to verify that we are providing quality care in a cost effective way. It is also a priority for Region 1 based upon the Community Needs Assessment. This effort meets CN.6 "Efficiency in and Effectiveness of Healthcare Delivery". To address this need we are initiating a two-phased process. First we are implementing a cost accounting system (P-3) and hiring and training staff (P-5.1) in order to identify all the specific/unique costs associated with our high volume admissions. . Thus, conducting a cost analysis (P-4) and establishing a baseline (P-2) for these high volume admissions. Understanding our cost is the first step in the cost reduction/elimination process. Secondly we will establish an Evidence-Based Care Plan, (EBCP), based upon research of best clinical practice. The EBCP will (1) reduce the variation in care thus driving down average cost and improving efficiency and (2) improve the quality of care using data from research. We will be implementing this EBCP in conjunction with expansion of hospitalist services. This will also enable us to provide patients with more care continuity. Currently patients in the hospital are cared for by PCPs and the patients are handed off each evening to the physician taking call. This can lead to confusion and/or improper patient management. Healthcare spending is a function of different factors and the ones we will be focusing on will by the volume, nature and intensity of services supplies or ordered, and the unit cost or price of services.

Core Project Components: There were no core project components specified for this project option.

Related Category 3 Outcome Measure: OD-5 Cost of Care
IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery

Relationship to other Projects: This project 131037704.2.1 may indirectly impact our category 1 project 131037704.1.1 because as part of reducing the cost of providing care , we are examining the opportunity to expand the hospitalist program. Expansion of hospitalist coverage will reduce the call and inpatient care responsibilities of our new PCPs and give them more time to see clinic patients. The cost accounting system will enable us to identify and disaggregate specific costs associated with each hospitalization. Then we can focus on the high impact areas for cost reduction. The processes developed through this endeavor should be reproducible and enable us to leverage our limited resources into focusing and reducing other significant cost of care issues.

Relationship to Other Performing Providers' Projects in the RHP: There are at least five other performing providers that have projects relating to CHF and/or cost containment and it is also emphasized in our region's community assessment.

Plan for Learning Collaborative: Hopkins County Memorial Hospital plans to participate in any RHP 1 learning collaborative with other performing providers in our region with projects related to the implementation of cost containment initiatives and improving the outcomes of CHF patients.

Project Valuation: The project will be valued on the benefit of having the staff to implement a cost accounting system, the ongoing outlay for maintaining the system, and the overall reduction in the difference of reimbursed and cost of care. We believe that our hospital experiences large gaps between the costs of providing care versus what is reimbursed based on cost to charge ratio calculations. The charges for the top ten DRGs, alone, this past fiscal year were around $14 million and based on our cost to charge ratio of 1.039243, the estimated cost for these DRGs was $14.5 million. The reimbursement for the same ten DRGs was approximately $7.425 million. Because cost to charge ratios are global in nature, more detailed information is needed in order to reduce cost. Thus, there will be great value in implementing a cost accounting system to solidify the true costs of providing care for specific DRGs. If costs are reduced by 3% through the use of a cost accounting system, evidenced based medicine and a reduction in variation of providing care it would have a direct impact on the viability of this facility. And part of this initiative is to expand our hospitalist program to help drive the cost reduction efforts and establish evidence based care plans. As the cost information improves, the ability to provide quality, evidence based medicine at the most economical cost will improve the health of our community and the overall financial outlook of the hospital. We are looking for the opportunity for the scope of this project to influence the management of all our admissions but more specifically our top 25 DRGs.

131037704.2.1	*2.5.3*	*NA*	*REDESIGN FOR COST CONTAINMENT*
Hopkins County Memorial Hospital			*131037704*
Related Category 3 Outcome Measure(s):	***131037704.3.2***	***3.2 IT 5.1***	***Cost of Care***

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1. P-3. Implement Cost accounting methodology. **Metric:** P-3.1. Installation of MEDITECH's cost-accounting system Goal: Cost accounting system installed Data Source: MEDITECH's implementation schedule of the cost-accounting system Milestone 1 Estimated Incentive Payment*:* $422,869	**Milestone 2**: P-5. Hire and train accounting staff on costing methodologies and define, develop, and document methodologies for allocation of costs **Metric:** P-5.1 Staff trainings and department specific methodologies Goal: Addition of one staff who is trained on cost accounting system Data Source: Training materials, cost-accounting system or another administrative, financial, or clinical data set. Milestone 2 Estimated Incentive Payment*: $245,080.66* **Milestone 3**: P-4. Conduct Cost Analysis **Metric:** P-4.1. Cost analysis results Goal: cost analysis completed Data Source: Cost analysis Milestone 3 Estimated Incentive Payment: $245,080.66 **Milestone 4**: P-2 Establish a baseline for cost **Metric:** P-2.1. Establish a baseline for cost top 25 DRGs	**Improvement Milestone 5**: I-7. Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost **Metric:** I-7.2 Demonstrate cost savings by cost containment Goal: 2% cost savings over baseline in gross charges in identified DRGs Data Source: Cost of Illness Analysis using cost accounting system and quality improvement process Milestone 5 Estimated Incentive Payment: $786,537	**Improvement Milestone 5**: I-7. Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost **Metric:** I-7.2 Demonstrate cost savings by cost containment Goal: 3% cost savings over baseline in gross charges in identified DRGs Data Source: Cost of Illness Analysis using cost accounting system and quality improvement process Milestone 6 Estimated Incentive Payment: $642,548

131037704.2.1	***2.5.3***	***NA***	***REDESIGN FOR COST CONTAINMENT***	
Hopkins County Memorial Hospital				***131037704***
Related Category 3 Outcome Measure(s):	***131037704.3.2***	***3.2 IT 5.1***	***Cost of Care***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Goal: Baseline established for specific DRGs Data Source: Cost-accounting system. Milestone 4 Estimated Incentive Payment: $245,080.67			
Year 2 Estimated Milestone Bundle Amount: $422,869	Year 3 Estimated Milestone Bundle Amount: $735,241		Year 4 Estimated Milestone Bundle Amount: $786,537	Year 5 Estimated Milestone Bundle Amount: $642,548
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,587,195				

Project Option:2.12.1 – Develop, implement, and evaluate standardized clinical protocols and evidence d based delivery models to improve care transitions.
Unique Project ID:131037704.2.2 (Pass 3)
Performing Provider Name/TPI: Hopkins County Memorial Hospital 131037704

Project Abstract

Provider Description: Hopkins County Memorial hospital is a 96 bed acute hospital located in Sulphur Springs with an estimated population of 18,000 and is the only hospital provider serving Hopkins County which has a population of approximately 30,000.
Intervention(s): This project will develop, implement and evaluate standardized clinical protocols and evidence based care delivery model to improve care transitions focusing on the congestive heart failure patients.
Need for the Project: Our goal is to decrease readmissions for a chronic diseases, reduce the high costs of potentially preventable hospitalizations and enhance the continuity of care to improve outcomes for our patients.
Target Population: The patient population with CHF admitted to our facility is approximately 100 patients per year with Medicaid and Uninsured being about 10%.
Category 1 or 2 Expended Patient Benefits: This project seeks to provide the development and implementation of standardized clinical protocols and evidenced based care delivery to decrease readmissions and the cost of care associated with readmissions.
Category 3 Outcomes: IT-3.2 Our goal is to reduce the readmission rate of CHF by 20% over the baseline by DY 5.

Project Narrative

Project Description: The project involves reducing potentially preventable readmissions by implementing the re-engineered discharge(RED) design. The goal of this project is to implement improvements in care transitions and coordination of care from the inpatient setting to post-acute or home care settings in order to prevent increased health care costs and hospital readmission. The focus will be on patients that are high risk for readmission in our market such as patients with diabetes, CHF or COPD. Hopkins County Memorial Hospital (HCMH) will create and implement discharge care protocols with the core components of (1) assignment of discharge advocates which in our case will consist of cardiac rehabilitation nurses, (2) development of specific after hospital care plans, and (3) frequent follow-up telephone calls to the patients' homes.

In order to meet the healthcare needs of our population in Northeast Texas, HCMH will be implementing protocols to decrease readmissions through improved discharge planning. Decreasing readmissions meets several community needs outlined by RHP 1 such as (1) high rates of chronic disease (CN.3), (2) high costs due to potentially preventable hospitalizations (CN.4) and (3) efficiency in and effectiveness of health care delivery (CN.6)

This project will address the required core components which are: (a) reviewing best practices from a range of models, (b) conducting an analysis of the key drivers of 30-day hospital readmissions, (c) integrating our information system, MEDITECH, so that continuity of care is enabled, (d) developing a system to identify patients being discharge potentially at risk for re-admission within 30 days, (e) implementing a discharge planning program and post discharge support program, (f) developing a cross-continuum team comprised of clinical and administrative staff, (g) conducting quality improvement methods such as lessons learned.

Starting Point/Baseline: HCMH has a case management team in place that does patient education and discharge planning and personnel to conduct follow up phone calls. However, the process lacks continuity and is somewhat disjointed between the physician, patient care provider in the hospital and case management. The discharge process and post hospital follow-up lacks consistency and is not hard wired. The baseline to identify the number of patients with a potentially high risk of readmission will need to be established in DY 2.

Rationale: After discharge from the hospital for a chronic condition such as congestive heart failure (CHF), many patients will be re-hospitalized. According to the National Healthcare Quality Report (NHQR),for example, almost one-third of CHF patients are readmitted within 30 days of discharge. A 2010 study by this group, the average cost of CHF readmission is $13,000 with Medicare expending $880 million annually. Although not all re-hospitalizations can be prevented, the risk of re-hospitalization may increase when patients do not follow their discharge instructions. When patients do not receive written discharge instructions that they understand, they are less able to follow them. Also, post discharge care should be coordinated with the patients' primary care physicians.

Patients cannot fully participate in their care after the hospital stays without sufficient understand of their diagnoses, medication and self-care needs. The lack of a complete and functional discharge process creates problems with the follow up care required from the medical staff. By focusing on potentially high risk patients in this initiative, HCMH will be able to provide significantly enhanced continuity of care for these patients improving their lives and outcomes and decreasing readmission rates. The comprehensive discharge planning will provide post discharge reinforcement of appropriate diet, fluid intake, use of medications and will have multiple benefits to the patient experience. It will enhance safety compliance, decrease readmissions and even perhaps return visits to the emergency department.

Core Project Components: This project will address the required core components which are: (a) reviewing best practices from a range of models, (b) conducting an analysis of the key drivers of 30-day hospital readmissions, (c) integrating our information system, MEDITECH, so that continuity of care is enabled, (d) developing a system to identify patients being discharge potentially at risk for re-admission within 30 days, (e) implementing a discharge planning program and post discharge support program, (f) developing a cross-continuum team comprised of clinical and administrative staff, (g) conducting quality improvement methods such as lessons learned.

Related Category 3 Outcome Measures: OD-3 Potentially Preventable Re-admission-30 day Readmission Rates IT 3.2 Congestive Heart Failure 30 day readmission rate

The goal of implementing this project is to reduce potentially preventable re-admissions (IT 3.2) by implementing the re-engineered discharge (RED) design for the CHF patient. The RED will focus on improving the discharge process and implementing protocols for follow-up phone calls and specific after hospital care plans. The goal is to decrease readmission of CHF by 20% over the baseline by DY5.

Relationships to other Projects: This project will impact our DSRIP project 131037704.3.2 of cost reduction measure for CHF patients through implementing a cost accounting system and DSRIP project 131037704.3.1, improving patient satisfaction scores. This project will also be impacted by DSRIP project 131037704.2.2, expanding primary care capacity when the CHF patient requires post discharge follow up care.

Relationship to Other Performing Providers' Projects in the RHP: This project meets the community needs of the RHP and will not duplicate services of other performing providers with in RHP 1. Congestive Heart Failure

was one of the highest potentially preventable hospitalizations and highest cost disease as stated in the RHP community needs assessment. There were 30,968 hospitalizations from 2005-2010 with total hospital charges of $796,053,057 and with the average hospitalization charge of $25,706.

Plan for Learning Collaborative: Hopkins County Memorial Hospital plans to participate in any RHP-wide learning collaborative offered to share ideas and best practices to reduce potentially preventable readmissions by the CHF patient.

Project Valuation: The benefits from the development and implementation of standardized clinical protocols and evidence based care delivery systems to improve care transitions will be advantageous to all our patient population. Taking one disease process such as CHF with an average of 100 admits per year and an approximate readmission rate of 25%, with an average cost of $13,000 per readmission, that is a cost of almost $250,000 for these readmissions. There is an opportunity for that potential cost saving in one year and that is only for one of the top admitted DRGs in our facility. If the development and implementation of clinical protocols to improve care transitions also reduces the follow up care in the Emergency Department and promotes follow up care with the primary care physician, there will be a cost savings between the two care settings. The patients will have better outcomes and an improved transition of care through the enhanced discharge process which will improve their health and lives. This project can also be valued by the opportunity for increased patient satisfaction.

131037704.2.2	*2.12.1*	*2.12.1 A-G*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*
Hopkins County Memorial Hospital			*131037704*
Related Category 3 Outcome Measure(s):	***131037704.3.4***	***3.4 IT 3.2***	***Congestive Heart Failure 30 day readmission rate***

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1. P-1. Develop or implement best practices or evidence-based protocols to improve adherence to discharge and follow-up care instructions **Metric:** P-1.1. Care transitions policies and procedures **Goal:** Develop appropriate and effective protocols for CHF patients **Data Source**: Documentation of protocols **Milestone 1 Estimated Incentive Payment*:*** $58,250 **Process Milestone 2:** Implement standardized care transition processes **Metric**: P-2.1 Care transitions policies and procedures **Goal:** Approve and implement CHF protocols **Data Source**: Minutes of service committee **Milestone 1 Estimated Incentive Payment*:*** $58,250	**Improvement Milestone 3**: I-14 Implement standard care transition process in specified patient population **Metric:** I-14.Measure adherence to processes **Goal**: 25% of patients adherence to processes **Data Source:** E.H.R. and Quality reports Milestone 3 Estimated Incentive Payment*: $138,139*	**Improvement Milestone 4**:I-11. Improve the percentage of patients in defined population receiving standardize care according to the approved clinical protocols and care transition policies **Metric:** I-11.1 Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines **Goal**: 10% increase of patients who receive the transition protocol over baseline **Data Source**: E.H.R. reports and analysis **Milestone 4 Estimated Incentive Payment:** $142,190	**Improvement Milestone 5**:I-11. Improve the percentage of patients in defined population receiving standardize care according to the approved clinical protocols and care transition policies **Metric:** I-11.1 Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines **Goal**: 20% increase of patients who receive the transition protocol over baseline **Data Source**: E.H.R. reports and analysis **Milestone 5 Estimated Incentive Payment:** $122,698

131037704.2.2	***2.12.1***	***2.12.1 A-G***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
Hopkins County Memorial Hospital				***131037704***
Related Category 3 Outcome Measure(s):	***131037704.3.4***	***3.4 IT 3.2***	***Congestive Heart Failure 30 day readmission rate***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $116,500	Year 3 Estimated Milestone Bundle Amount: $138,139		Year 4 Estimated Milestone Bundle Amount: $142,190	Year 5 Estimated Milestone Bundle Amount: $122,698
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $519,527				

Project Option 2.9.1 – Provide Navigation Services to Targeted Patients Who Are at High Risk of Disconnect from Institutionalized Health Care.
Unique Project ID: 131038504.2.1 (Pass 1)
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Project Abstract

Provider Description: Hunt Regional Medical Center (HRMC) is a 192 bed regional hospital operating within Hunt Memorial Hospital District. Hunt Regional Medical Center is located in Greenville and serves 86,129 residents, covering 882 square miles in Hunt County. In fiscal year 2011 HRMC had 29,820 inpatient days, 6,592 inpatient admissions and 2,804 observation visits.

Interventions: This project will implement a patient navigation program in the Emergency Department to patients with high medical and social needs. The patient navigation program will use community health workers to conduct home visits and nurse/social worker navigators to perform intensive case management and disease self-management patient education.

Need for the Project: Hunt County has significant healthcare barriers in healthcare delivery including deficits in primary care, higher than average occurrence of chronic illnesses and an increasing uninsured population. In 2011, the HRMC Emergency Department had 5,899 Level 1, 2, 3 visits which would be appropriate in the primary care setting.

Target Population: The target population of this project is the Hunt County Medicaid and indigent population who are the largest ED utilizers. In fiscal year 2012, the ED at HRMC had 45,543 total visits. Of these visits 55.6% were the Medicaid (23.8%) and indigent population (31.8%) resulting in 25,310 Medicaid and indigent Emergency Depart visits.

Category 1 Expected Benefit: The 5 year expected outcome of this project is to provide navigation services to 2,250 Medicaid and indigent frequent ED user patients enrolled in the patient care navigation program. By demonstration year we estimate providing:

- Demonstration year 3: navigation services to 500 patients (50% of navigation services target case load)
- Demonstration year 4: navigation services to 750 patients (75% of navigation services case load) and arranging a primary care appointment with 375 patients (50% of DY 4 target case load)
- Demonstration year 5: navigation services to 1000 patients (target case load) and arranging a primary care appointment with 750 patients (75% of DY 5 case load)

Category 3 Outcome: The patient navigation project is expected to reduce ED utilization.

Project Narrative

Project Description:
Goals
The overarching goal of the Northeast Texas Regional Healthcare Partnership (RHP 1) is to improve patient experience and health at a reduced cost. Consistent with that goal, a priority focus in Region 1 is implementing a comprehensive, coordinated approach to managing chronic illnesses. In line with The Triple Aim goals to "have improved individual health outcomes and better experience of care at lower overall per capita costs" (Bisognano and Kenney, 2012), the goal of the patient navigation program is to facilitate and

support patients as they navigate through the continuum of healthcare services by providing patients with coordinated, timely care.

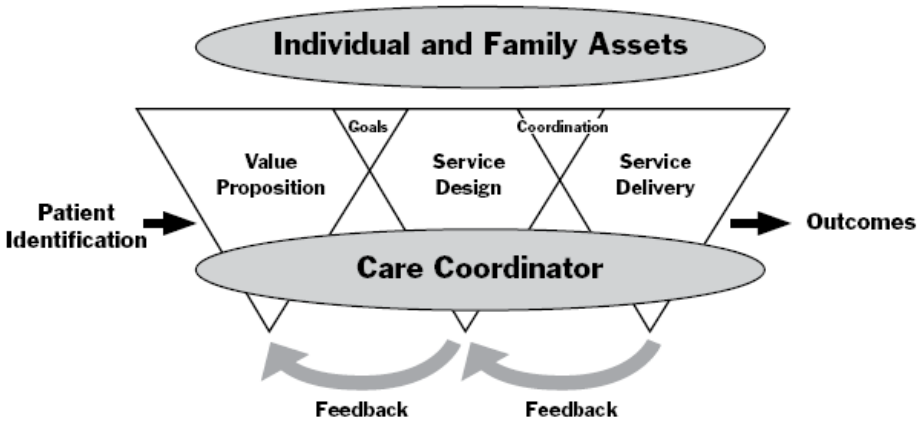
Challenges

There are multiple challenges to implementing a patient navigation program. The first barrier will be correctly identifying the high risk population of patients with multiple health and social needs. System related challenges include securing the multidisciplinary staff to implement the navigation program, implementing the operational aspects of the program and healthcare worker education. Patient related challenges include transportation, obtaining medications and motivation. The forthcoming project description outlines specific interventions and solutions to facilitate patient care navigation.

Delivery System Solution

Hunt Regional Medical Center plans to utilize the Institute for Healthcare Improvement Care Coordination Model to support the needs of patients with multiple health and social needs (Craig, Eby, and Whittington, 2011).

Figure 1. IHI Care Coordination Model for People with Multiple Health and Social Needs



Hunt Regional Medical Center proposes to develop a navigation program in partnership with American Medical Response, our ambulance provider. Through this partnership we plan to implement intense, frequent home visits by emergency medical technicians and paramedics (community health workers) to patients identified as high Emergency Department users. We also plan to hire two nurse patient navigators in the Emergency Department and expand social work coverage in the ED to cover evenings and week-ends. The nurse navigators and social workers will provide intensive case management, in conjunction with the community health workers, to patients with high medical and social needs. The patient navigator role will include: (1) assessment of patient needs, (2) review patient care plans to ensure evidence based best practices are implemented and accurate medication reconciliation is in place, (3) coordinate primary and specialty care visits, (4) communicate health information to providers, (5) provide patient/family self-management tools and disease education, (6) conduct telephone follow-up and (7) assist patients to connect with outpatient resources.

The patient navigators and community health workers will be trained in cultural competency and best practices in care coordination. We will also purchase software that will identify and flag the record of ED super-users. In addition we will develop a Guide to Outpatient and Community Services to be distributed to patients, community agencies and healthcare providers.

Oversight of the patient navigation program will be guided by a multidisciplinary team who will direct patient care plans, develop self-management education material and conduct performance improvement. Tracking and measuring the impact of the patient navigation program will be critical to the program's success to ensure the program is having the expected effect of improved patient outcomes and experience in the most appropriate setting. Performance improvement is also necessary to identify what specific interventions are the most effective. To direct interventions for the patient navigation program we will implement rapid cycle improvement quality methodology.

Expected Outcome

The 5 year expected outcome of this project is to provide navigation services to 2,250 Medicaid and indigent frequent ED user patients enrolled in the patient care navigation program. By demonstration year we estimate providing:

- Demonstration year 3: navigation services to 500 patients (50% of navigation services target case load)
- Demonstration year 4: navigation services to 750 patients (75% of navigation services case load) and arranging a primary care appointment with 375 patients (50% of DY 4 target case load)
- Demonstration year 5: navigation services to 1000 patients (target case load) and arranging a primary care appointment with 750 patients (75% of DY 5 case load)

Additional expected outcomes of the project are a 25% reduction in non-emergent and chronic disease exacerbation ED visits in patients enrolled in the patient care navigation program, increased access to healthcare in our medically underserved community and improved patient experience.

Starting Point:

In fiscal year 2012, the Emergency Department at HRMC had 45,543 total visits. Of these visits 55.6% were the Medicaid (23.8%) and indigent population (31.8%). Currently HRMC has one Emergency Department social worker who provides outpatient referrals and resources to patients with high medical and social needs. HRMC also has social work coverage on all of the inpatient and observation units. However, we do not currently have a patient navigation program in place. The total all cause readmission rate for Hunt Regional Medical Center from January – December 2011 was 9.60%.

Rationale:

The patient care navigation program addresses several Northeast Texas Regional Healthcare Partnership (RHP 1) community needs including:

- CN.1: Insufficient access to primary and specialty care services
- CN.3: High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
- CN.4: High costs due to potentially preventable hospitalizations.
- CN.5: Inappropriate emergency room utilization.
- CN.6: Efficiency in and effectiveness of health care delivery.

Hunt County has significant healthcare barriers in healthcare delivery including deficits in primary care (CN. 1, 4), higher than average occurrence of chronic illnesses (CN. 3) and an increasing uninsured population (CN. 6). In 2011, the HRMC Emergency Department had 5,899 Level 1, 2, 3 visits which could be appropriate in the primary care setting (CN.5). Additionally, based on CMS discharge data the HRMC 30 day readmission rates during the baseline period of July 1, 2008- June 30, 2011 were slightly higher than national averages. HRMC's acute myocardial infarction 30 day readmission rate was 22.3% compared to the national average of 19.8%. HRMC's heart failure 30 day readmission rate was 25.7% compared to the national average of 24.8% and HRMC's pneumonia 30 day readmission rate was 19.4% compared to 18.4% nationally.

We selected this priority project because implementing a patient navigation program will increase access to outpatient care for patients with high medical and social needs and decrease non-emergent ED use and preventable readmissions. The HRMC patient care navigation program encompasses all the required core components of Project Option 2.9.1 including: (a) identification of frequent ED users and the use of culturally competent navigators to reduce non-emergent ED visits, (b) deployment of innovative health care personnel as patient navigators, (c) connecting patients to primary and preventative care, (d) increasing access to case management including education in chronic disease self-management and (e) quality improvement.

We have selected milestones and metrics for this project to measure progress in developing a patient navigation program to facilitate and support patients navigate through the continuum of healthcare services providing patients with coordinated, timely care. The process milestones include conducting a patient navigation needs assessment, training patient navigators, providing patient navigation home visits to high risk, super-user patients and participating in a regional learning collaborative. The improvement milestones include measuring the number of primary care referrals for patients without a medical home and the reduction in ED use by identified ED frequent users. This initiative is a new service at Hunt Regional Medical Center and does not duplicate any funding by the U.S. Department of Health and Human Services.

Related Category 3 Outcome Measure:
The objective of patient navigation is to facilitate and support patients as they navigate through the healthcare system while providing patients with coordinated, timely care. To demonstrate improved patient health outcomes and experience while decreasing costs, Hunt Regional Medical Center has selected Improvement Target- 9.2, ED appropriate utilization. As identified in the community needs assessment, RHP 1 has significant healthcare delivery barriers including deficits in primary care (CN. 1), higher than average occurrence of chronic illnesses (CN. 3) and an increasing uninsured population. All of these barriers result in non-emergent ED visits (CN. 5). We selected this improvement target because it specifically measures the desired end result of reduced ED utilization achieved by patient navigation to coordinate care in the most appropriate setting.

Relationship to Other Projects:
Establishing a patient care navigation program will serve a supporting and reinforcing role to other DSRIP projects. Patient care navigation is associated with improved patient outcomes and experience in the most appropriate setting. Establishing a patient care navigation program relates to other projects including:

Category I Projects
1310385-04.1.1 Expanding primary care capacity will support a patient navigation program by offering primary care access to patients with high medical and social needs.
Category II Projects
1310385-04.2.2 Patient navigation will support care transitions by augmenting the discharge process and transition home with additional care coordination.
Category IV Projects
(4.1) Potentially Preventable Admissions
(4.2) 15-day Readmissions
(4.3) Potentially Preventable Complications
(4.4) Patient Centered Healthcare, including patient satisfaction and medication management
(4.5) Emergency Department

Relationship to Other Performing Providers' Projects in RHP 1:

Improving healthcare delivery, ED utilization and chronic care management are regional priorities. Other regional partners that will be implementing/expanding a patient care navigation program include: the East Texas Medical Center system and University Physician Associates. Hunt Regional Medical Center plans to participate in a regional patient care navigation learning collaborative to share best practices, new ideas and solutions.

Plan for Learning Collaborative:
Hunt Regional Medical Center will participate in the regional learning collaborative to establish patient care navigation programs. The learning collaborative will consist of sharing best practices through webinars and meetings to brainstorm ideas and present experiences from successful interventions. The region will establish quantifiable goals to drive project implementation and measure progression with supporting data. The learning collaborative will also identify implementation challenges and solutions.

Project Valuation:
Hunt County residents have many medical and social challenges that impact health. According to the Institute for Healthcare Improvement (Craig, Eby and Whittington, 2011), people with multiple health and social needs have better outcomes and experience in the most appropriate setting when they have ongoing care coordination to support complex health needs. Hunt County ranks 155 out of 221 counties for health indicators in Texas. The premature death rate for persons who died younger than age 75 is 10,114/100,000 population compared to a state average of 7,186/100,000. Chronic health conditions for Hunt County include an above state average number of residents with diabetes, cardiovascular disease, cancer and Alzheimer's disease (County Health Rankings and Roadmaps, 2012.) Social challenges in Hunt County are a large geographic area with limited public transportation, limited public housing and a high percent of under- and un- insured residents.

The patient navigation valuation approach included accounting for the significant large scope of the project and the healthcare delivery barriers of increasing rates of un-insured patients, primary care deficits/underutilization (CN. 1), increased chronic illness (CN. 3), lack of transportation and increasing non-emergent ED encounters (CN. 5). This project also works in tandem with the primary care and care transitions projects to improve patient outcomes while reducing preventable admissions, readmissions, complications and Emergency Department utilization. The costs associated with this project include:

- Patient navigators (2 community health workers, 2 nurse case managers and 2 social workers)
- Navigator home visit transportation including car rental, gas, maintenance, insurance
- Contracting with Hunt County Committee of Aging for patient transportation
- Patient supplies including medications, food and medical equipment
- Electronic medical record tool to track and monitor super users

References:
Bisognano M, Kenney C. (2012). Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs. San Francisco: Jossey-Bass Publishers.

Craig C, Eby D, Whittington J. (2011). *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Institute for Healthcare Improvement. Available at:
http://www.ihi.org/knowledge/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Population Health Institute at the University of Wisconsin, County Health Rankings and Roadmaps, 2012. Available at: http://www.countyhealthrankings.org/#app/texas/2012/hunt/county/1/overall

Process Milestones/Outcome Improvement Target Table

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE
131038504.2.1	2.9.1	2.9.1 A,B,C,D,E	ENHANCE/EXPAND A PATIENT CARE NAVIGATION PROGRAM
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.2	Reference number IT-9.2	Outcome Measure ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1] Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1]: Provide report identifying the following: • Targeted patient population characteristics • Gaps in services and service needs • Policy/Procedure, referral and navigation protocols, service maps and flowcharts outlining how the program will identify, triage and manage target population • Ideal number of patients targeted for enrollment • Number of patient navigators needed to be hired • Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients Baseline/Goal: Complete a navigation/ED super-user needs assessment and service plan Data Source:	**Milestone 3 [P-2]** Establish/expand a health care navigation program to provide support to patient populations who are at most risk of receiving disconnected and fragmented care including a program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.1]: Number of people trained as patient navigators Baseline/Goal: Four healthcare workers will be trained as patient navigators. Data Source: Workforce development plan for patient navigator recruitment, training and education. Milestone 3 Estimated Incentive Payment*:* $711,975.33 **Milestone 4 [P-3]** Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program a. Numerator: Number of targeted patients	**Milestone 6 [P-3]** Provide care management/navigation services to targeted patients. Metric 1[P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Numerator: Number of targeted patients enrolled in the program Denominator: Total number of targeted patients identified Target Population/Goal: Target Population: ED frequent user population with the most frequent ED visits. Target patients enrolled in navigation program= 1000 Goal: Increase the number of targeted patients enrolled in the program by 75%/750patients. Data Source: Enrollment reports/medical records Milestone 6 Estimated Incentive Payment *(maximum amount):* $714,045 **Milestone 7 [I-6]** Increase number of PCP referrals for	**Milestone 9 [I-6]** Increase number of PCP referrals for patients without medical homes who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment a. Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. b. Denominator: Number of patients without a PCP document in their medical record using the care navigation program. Baseline/Goal: Goal: Increase the number of ED frequent user patients without a PCP documented in their medical record an appointment scheduled by 75% or 750 patients enrolled in the navigation program will have an appointment scheduled with a PCP. *Note- the case load of the patient care navigation program is expected to be 1000 patients in DY 5. Data Source: Performing provider administrative data set on patient

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE
131038504.2.1	2.9.1	2.9.1 A,B,C,D,E	ENHANCE/EXPAND A PATIENT CARE NAVIGATION PROGRAM
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.2	Reference number IT-9.2	Outcome Measure ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Program documentation, EHR, claims, needs assessment survey Milestone 1 Estimated Incentive Payment: $978,932.50 **Milestone 2: [P-8]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-8.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.	enrolled in the program b. Denominator: Total number of targeted patients identified Target Population/Goal: Target Population: ED frequent user population with the most frequent ED visits. Target patients enrolled in navigation program= 1000 Goal: Increase the number of targeted patients enrolled in the program by 50%/500patients. Data Source: Enrollment reports/medical records Milestone 4 Estimated Incentive Payment: $711,975.33 **Milestone 5: [P-8]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	patients without medical homes who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment a. Numerator: Number of patients without a PCP documented in their medical record that receive an appointment with a PCP as a function of the care navigation program. b. Denominator: Number of patients without a PCP documented in their medical record using the care navigation program. Baseline/Goal: Goal: Increase the number of ED frequent user patients without a PCP documented in their medical record an appointment scheduled by 50% or 375 patients enrolled in the navigation program will have an appointment scheduled with a PCP. *Note- the case load of the patient care navigation program is expected to be 750 patients in DY 4. Data Source: Performing provider administrative data set on patient encounters and scheduling records from patient navigator program. Milestone 7 Estimated Incentive Payment:	encounters and scheduling records from patient navigator program. Milestone 9 Estimated Incentive Payment: $589,863 **Milestone 10 [I-8]** Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and post- navigation services by individuals identified as ED frequent users. a. Difference in total number of ED visits pre- and post- navigation services. Baseline/Goal: A 25% reduction in ED visits post navigation services by individuals identified as ED frequent users. Data Source: Claims and EHR Milestone 10 Estimated Incentive Payment: $589,863 **Milestone 11: [P-8]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.2.1	2.9.1	2.9.1 A,B,C,D,E	ENHANCE/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.2	Reference number IT-9.2	Outcome Measure ED appropriate utilization	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 Estimated Incentive Payment: $978,932.50	Metric 1: [P-8.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $711,975.33	$714,045 **Milestone 8: [P-8]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-8.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $714,045	face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: [P-8.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 11 Estimated Incentive Payment: $589,863

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.2.1	2.9.1	2.9.1 A,B,C,D,E	ENHANCE/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.2	Reference number IT-9.2	Outcome Measure ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount:: $1,957,865	Year 3 Estimated Milestone Bundle Amount: $2,135,926		Year 4 Estimated Milestone Bundle Amount: $2,142,135	Year 5 Estimated Milestone Bundle Amount: $1,769,589
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $8,005,515				

Project Option 2.12.1 – Implement/Expand Care Transitions Program- Develop, Implement and Evaluate Standardized Clinical Protocols and Evidence-Based Model
Unique Project ID: 131038504.2.2 (Pass 1)
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Project Abstract

Provider Description: Hunt Regional Medical Center (HRMC) is a 192 bed regional hospital operating within Hunt Memorial Hospital District. Hunt Regional Medical Center is located in Greenville and serves 86,129 residents, covering 882 square miles in Hunt County. In fiscal year 2011 HRMC had 29,820 inpatient days, 6,592 inpatient admissions and 2,804 observation visits.

Interventions: This project will implement a care transitions program to create a smooth, coordinated hospital discharge. Interventions will include implementing Project RED (Re-Engineered Discharge) to perform discharge planning, education, medication management and coordinate outpatient follow-up.

Need for the Project: Implementing a care transition project is foundational to other outpatient care coordination initiatives and is associated with reduced hospital readmissions. Hunt Regional Medical Center has a higher than national average rate of hospital readmissions.

Target Population: The target population of this project is HRMC patients with chronic conditions and patients who are at a high risk of being disfranchised from primary care including the Medicaid and indigent population. Hunt Regional is a public hospital with a payor mix of 12.3% Medicaid and 14.7% indigent (2011). In 2011, 651 Medicaid and indigent adult patients with medical DRG's were discharged from HRMC. It is estimated that approximately 1,950 Medicaid and indigent patients would directly benefit from this project throughout the demonstration.

Category 1 Expected Benefit: The 5 year expected outcome of the project are 4,640 patients or 85% of patients identified as high risk for readmission will receive standardized transition education. We plan to provide care transition services to 2,175 patients by demonstration year 4 and 2,465 patients by demonstration year 5. Additional expected outcomes are a reduction in preventable admissions/readmissions and ED utilization, improved patient experience and improved transitions to primary care.

Category 3 Outcome: The care transition project is expected to reduce the all cause 30 day readmission rate.

Project Narrative

Project Description:

Goals

Hospital readmissions are a healthcare delivery system wide problem. Many outpatient factors affect reducing hospital readmissions, albeit the process starts in the hospital. Standardized, thorough discharge planning is associated with improved health outcomes and reduced hospital readmissions (Jencks, 2010). The overarching goal of the Northeast Texas Regional Healthcare Partnership (RHP 1) is to improve patient experience and health at a reduced cost. Transitioning from providing acute, episodic care to a more proactive, coordinated system of care is a regional focus to effectively manage the high chronic condition population in Northeast Texas. The goal of expanding care transitions is to improve the discharge process to create a smooth, coordinated transition from the inpatient setting to home.

Challenges

The challenges of implementing a standardized discharge process are operational and will require system innovation and redesign. Barriers include the methodology to identify patients at high risk of readmission, a lack of discharge instruction software that interfaces with our electronic medical record, best practice protocols, patient education tools and healthcare worker education. The forthcoming project description outlines specific interventions and solutions to support care transitions and implementing Project RED at HRMC.

Delivery System Solution

To expand the care transitions program at Hunt Regional we will begin the process by forming a cross-continuum multidisciplinary team including medical, nursing, social work, pharmacy, skilled nursing and home health staff to review evidence based, care transition best practices. Further, we will conduct an analysis of the root causes of readmissions in our community using the Institute for Healthcare Improvement STAAR chart review tool and conduct interviews with patients who are readmitted to the hospital. Following our review of best practices and analysis of key drivers of readmissions, the multidisciplinary team will form a quality improvement plan utilizing the rapid cycle improvement methodology to set performance improvement indicators to track progress and identify value added transition interventions.

The cross-continuum multidisciplinary team will also review tools to identify patients at high risk of readmission and work with the Information Systems Department to build a screening tool into the electronic medical record that will flag patient's records needing intense care transition interventions. In addition, we plan to purchase discharge instruction software that will interface with our electronic medical record to provide comprehensive, standardized discharge instructions.

Hunt Regional Medical Center will implement Project RED (re-engineered discharge) to improve the discharge process and reduce preventable readmissions. Project RED is a comprehensive discharge program that utilizes strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates (Boston Medical Center Corporation, 2006). We will hire discharge advocates to complete discharge planning and provide Project RED education to the medical and nursing staff.

Components of the Re-Engineered Discharge (RED) to be implemented by Discharge Advocates:

- Educate the patient about his or her diagnosis throughout the hospital stay
- Make appointments for clinician follow-up
- Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results
- Organize post-discharge services
- Confirm the Medication Plan
- Reconcile the discharge plan with national guidelines and clinical pathways
- Review the appropriate steps for what to do if a problem arises
- Assess the degree of understanding by asking the patient to explain in their own words the details of the plan using the teach back method
- Give the patient a written discharge plan at the time of discharge
- Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge

Expected Outcome

The 5 year expected outcome of the project are 4,640 patients or 75% of patients identified as high risk for readmission will receive standardized transition education. We plan to provide care transition services to 2,175 patients by demonstration year 4 and 2,465 patients by demonstration year 5. Additional expected outcomes of implementing post discharge support utilizing the Re-Engineered Discharge process are: (1) a reduction in preventable readmissions, (2) improvement in patient experience, (3) reduction in avoidable ED visits for exacerbations of chronic illness and inability to obtain post discharge medications and (4) improved transitions to primary care.

Starting Point/Baseline:

Hunt Regional Medical Center currently provides post discharge follow-up appointments and discharge instructions, however there is not a standardized set of instructions implementing all discharge best practices in place. The total readmission rate for Hunt Regional Medical Center in calendar year 2011 was 9.60%.

Rationale:

The patient care navigation program addresses several Northeast Texas Regional Healthcare Partnership (RHP 1) community needs including:

- CN.3: High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer.
- CN.4: High costs due to potentially preventable hospitalizations.
- CN.5: Inappropriate emergency room utilization.
- CN.6: Efficiency in and effectiveness of health care delivery.

Hunt Regional chose this project because providing a smooth transition process is foundational to other outpatient care coordination initiatives. Hunt County has a high occurrence of chronic illnesses (CN. 3). Improved care transitions are especially important in the chronic condition population to coordinate care, medication and provide education to facilitate self-management. Improved care transitions will also reduce preventable admissions (CN. 4), complications and Emergency Department utilization (CN. 5). Additionally, improved care transitions will reduce hospital readmissions (CN. 6) by creating a smooth, coordinated transition from the inpatient setting to home. Based on CMS discharge data the HRMC 30 day readmission rates during the baseline period of July 1, 2008- June 30, 2011 were slightly higher than national averages. HRMC's acute myocardial infarction 30 day readmission rate was 22.3% compared to the national average of 19.8%. HRMC's heart failure 30 day readmission rate was 25.7% compared to the national average of 24.8% and HRMC's pneumonia 30 day readmission rate was 19.4% compared to 18.4% nationally.

The HRMC care transitions program encompasses all the required core components of Project Option 2.12.1 including:

(a) Review best practices from a range of models
(b) Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool and patient interviews
(c) Integrate information systems so that continuity of care for patients is enabled
(d) Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days
(e) Implement a discharge planning and post discharge support program
(f) Develop a cross-continuum team
(g) Conduct quality improvement

We have selected milestones and metrics for this project to capture success in redesigning the discharge process to foster a smooth, coordinated transition from the inpatient setting to home. The process milestones

include developing care transitions evidence based protocols, development of a care transitions staffing and implementation plan and implementation of a validated risk assessment tool. Improvement milestones include the completion of a root cause analysis on the cause of readmissions and improving the percentage of patients in a defined population receiving comprehensive, standardized transition plans. The expansion of care transitions will significantly enhance our current discharge process. HRMC does not have any other initiatives funded by the U.S. Department of Health and Human Services.

Related Category 3 Outcome Measure:
In a recent study published in the Annuals of Internal Medicine, implementing a standardized, comprehensive discharge reduced subsequent hospital utilization by 30% including hospital readmissions and Emergency Department visits (Jack et al., 2009). Expanding care transitions is expected to result in improved patient outcomes and reduced hospital readmissions. To demonstrate improved outcomes with fewer readmissions, Hunt Regional Medical Center has selected Improvement Target- 3.1, all cause 30 day readmission rate. We selected this improved target because reducing preventable readmissions is this projects specific objective and reflects success expanding care transitions.

Relationship to Other Projects:
Standardized, thorough discharge planning is associated with improved health outcomes and reduced readmissions. Expanding care transition programs will serve a supporting and reinforcing role to other DSRIP projects including:

Category I Projects
1310385-04.1.1 Primary care supports expanding care transitions by offering patients access to primary care and follow-up upon discharge.
Category II Projects
1310385-04.2.1 Implementing patient navigation relates to improving care transitions by assisting patients identify outpatient resources and improved care coordination.
Category IV Projects
(4.1) Potentially Preventable Admissions
(4.2) 15-day readmissions
(4.3) Potentially Preventable Complications
(4.4) Patient Centered Healthcare, including patient satisfaction and medication management
(4.5) Emergency Department

Relationship to Other Performing Providers in RHP 1:
Improving healthcare delivery and chronic care management are regional priorities. Other regional partners that will be expanding care transitions include: the East Texas Medical Center system and St. Michael's Health System. Hunt Regional Medical Center plans to participate in a regional care transitions learning collaborative to share best practices, new ideas and solutions.

Plan for Learning Collaborative:
Hunt Regional Medical Center will participate in a regional learning collaborative. The learning collaborative will consist of sharing best practices through webinars and meetings to brainstorm ideas and present experiences from successful interventions. The region will establish quantifiable goals to drive project implementation and measure progression with supporting data. The learning collaborative will also identify implementation challenges and solutions.

Project Valuation:
The lack of thorough, comprehensive care transitions often result in rapid, preventable re-hospitalization (Golden, Tewary, Dang and Roos, 2010). The care transitions valuation approach included accounting for the importance of providing a smooth transition process that is foundational to outpatient care. We selected this project because it works in conjunction with the primary care and patient navigation projects to improve patient outcomes while reducing preventable admissions (CN. 4), readmissions (CN. 6), complications and Emergency Department utilization (CN. 5).

Chronic conditions are a strong predictor of hospital readmission. Hunt County residents have an increased occurrence of chronic conditions including diabetes, cardiovascular disease, cancer and obesity (County Health Rankings and Roadmaps, 2012.) Additionally, based on CMS discharge data the HRMC 30 day readmission rates during the baseline period of July 1, 2008- June 30, 2011 were slightly higher than national averages. HRMC's acute myocardial infarction 30 day readmission rate was 22.3% compared to the national average of 19.8%. HRMC's heart failure 30 day readmission rate was 25.7% compared to the national average of 24.8% and HRMC's pneumonia 30 day readmission rate was 19.4% compared to 18.4% nationally. The cost associated with this project includes hiring and training discharge advocates, care transition tools and discharge instruction (Project RED) software.

References:
Boston Medical Center Corporation (2006). Project RED Re-Engineered Discharge. Available at: http://www.bu.edu/fammed/projectred/

Golden, A.G., Tewary, S., Dang, S., Roos, B.A., 2010. Care management's challenges and opportunities to reduce the rapid rehospitalization of frail community-dwelling older adults. *The Gerontologist*. 2010; 50(4):451-458. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20185522

Jack, B., et al. (2009). A reengineered hospital discharge program to reduce Rehospitalizations. *Annuals of Internal Medicine,* 150:178-187. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738592/

Jencks, S. F. (2010). Defragmenting care. *Annals of Internal Medicine, 153* (11), 757-758. Available at: http://annals.org/article.aspx?articleid=746539

Population Health Institute at the University of Wisconsin, County Health Rankings and Roadmaps, 2012. Available at: http://www.countyhealthrankings.org/#app/texas/2012/hunt/county/1/overall

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.2.2	2.12	2.12.1 A,B,C,D,E,F,G	IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.3	Reference number IT- 3.1	Outcome Measure All cause 30 day readmission rate	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1] Develop or implement best practices or evidence based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions. Metric 1 [P-1.1]: Care transitions protocols a. Submission of protocols b. Data source: Policies and procedures of care transitions program materials Baseline/Goal: Develop care transition best practice policies and protocols to implement Project RED. Milestone 1 Estimated Incentive Payment: $187,628.67 **Milestone 2 [P-7]** Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program. Metric 1 [P-7.1] Documentation of the staffing plan. Baseline/Goal: Develop a care transitions staffing and implementation plan that	**Milestone 4 [P-5]** Using a validated risk assessment tool, create a patient identification system. Metric 1 [P-5.1] Patient stratification system Baseline/Goal: Develop and implement a validated risk assessment in the electronic medical record that identifies patients requiring intense care transition interventions. Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization of report findings. Milestone 4 Estimated Incentive Payment: $204,693 **Milestone 5 [I-10]** Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions. Metric 1 [I-10.1] Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of readmission.	**Milestone 7 [I-11]** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1] Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. A. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for care transition services. Baseline: 2,886 adult medicine inpatient discharges (2011) Goal: 75% of adult medicine discharges/ 2,175 patients in the target population per year will receive all recommended care transition education per protocol. *Target population is 2,900 adult medicine patients (excluding surgical, pediatric, obstetrics, behavioral health and rehab discharges)	**Milestone 9 [I-11]** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1] Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. A. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for care transition services. Baseline: 2,886 adult medicine inpatient discharges (2011) Goal: 85% of adult medicine discharges/ 2,465 patients in the target population per year will receive all recommended care transition education per protocol. *Target population is 2,900 adult medicine patients (excluding surgical, pediatric, obstetrics, behavioral health and rehab discharges)

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE
131038504.2.2	2.12	2.12.1 A,B,C,D,E,F,G	IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.3	Reference number IT- 3.1	Outcome Measure All cause 30 day readmission rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
outlines the program goals/objectives, job functions and description. Data Source: Staffing and implementation plan. Milestone 2 Estimated Incentive Payment*:* $187,628.67 **Milestone 3: [P-12]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1: [P-12.1]</u> Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement.	a. List by frequency of most prevalent chronic conditions, patient factor, or other socioeconomic factors in patient panel resulting in highest readmission rates. Baseline/Goal: Establish a baseline all-cause and specific chronic condition readmission rates identifying the most common readmission conditions. Conduct a review on a sampling of readmitted patients to identify patient characteristics, socioeconomic and disease specific factors resulting in readmissions. Data Source: EHR report/analysis Milestone 5 Estimated Incentive Payment: $204,693 **Milestone 6: [P-12]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	Data Source: EHR reports/analysis Milestone 7 Estimated Incentive Payment:$ 307,932 **Milestone 8: [P-12]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1: [P-12.1]</u> Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from	. Data Source: EHR reports/analysis Milestone 9 Estimated Incentive Payment: $254,378.50 **Milestone 10: [P-12]** Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1: [P-12.1]</u> Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source:

PROJECT IDENTIFIER	PROJECT	PROJECT COMPONENTS	PROJECT TITLE	
131038504.2.2	2.12	2.12.1 A,B,C,D,E,F,G	IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS	
RHP Performing Provider: Hunt Regional Medical Center Greenville				PERFORMING PROVIDER TPI: 131038504
Related Category 3 Outcome Measure(s):	Category 3 IT identifier 131038504.3.3	Reference number IT- 3.1	Outcome Measure All cause 30 day readmission rate	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment*:* $187,628.67	Metric 1: [P-12.1] Participate in semi-annual face to face meetings or seminars organized by the RHP. Baseline/Goal: Attend/participate in 2 regional collaborative learning seminars per year aimed at performance improvement. Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment*:* $204,693		presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment*:* $307,932	Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 10 Estimated Incentive Payment*:* $254,378.50
Year 2 Estimated Milestone Bundle Amount*:*: $562,886	Year 3 Estimated Milestone Bundle Amount: $614,079		Year 4 Estimated Milestone Bundle Amount: $615,864	Year 5 Estimated Milestone Bundle Amount: $508,757
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,301,586				

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 136140407.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Mt. Vernon 136140407

Project Abstract

Provider: East Texas Medical Center Mt. Vernon (ETMC) is a 49-bed, full-service hospital dedicated to serving the Franklin County area with advanced diagnostics, medical and surgical care, and outpatient services. ETMC's primary service area is Franklin County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 120,272.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 205 new primary care clinic patients each year with a Medicaid and indigent share of at least 25%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 15% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, estimated at 308 patients. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 15% of non-urgent emergency room patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 3,014 emergency room visits in 2012—including 2,055 non-urgent visits (68.2%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Mt. Vernon		
Level of Care	**ED Visits**	**Percent**
Unknown	1	0.0%
1 Resuscitation	7	0.2%
2 Emergent	32	1.1%
3 Urgent	919	30.5%
4 Semi Urgent	1,587	52.7%
5 Non Urgent	468	15.5%
Grand Total	**3,014**	**100.0%**
Percent Non-Urgent	2,055	68.2%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (136140407.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (136140407.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (136140407.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease

avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $162,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $133,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		2,055
% Clinic Appropriate		15%
Clinic Appropriate Patients		308
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**208,189**
Clinic Payment @ 78% savings	$	45,802
Total Estimated Savings	**$**	**162,387**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

136140407.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Mt. Vernon			*136140407*
Related Category 3 Outcome Measure(s):	***136140407.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $105,244	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [103] out of a baseline of 2,055 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $114,815	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [205] out of a baseline of 2,055 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $115,149	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 15% [308] out of a baseline of 2,055 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $95,123
Year 2 Estimated Total DSRIP: $105,244	Year 3 Estimated Total DSRIP: $114,815	Year 4 Estimated Total DSRIP: $115,149	Year 5 Estimated Total DSRIP: $95,123
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$430,331***			

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 137319306.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Crockett 137319306

Project Abstract

Provider: East Texas Medical Center Crockett (ETMC) is a 49-bed, full-service hospital dedicated to serving the Houston County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Houston County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 94,915.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 773 new primary care clinic patients each year with a Medicaid and indigent share of at least 25%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 17% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 1,315 ER referrals. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 17% of non-urgent emergency room patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 13,903 emergency room visits in 2012—including 7,733 non-urgent visits (55.6%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Crockett		
Level of Care	**ED Visits**	**Percent**
Unknown	100	0.7%
1 Resuscitation	26	0.2%
2 Emergent	719	5.2%
3 Urgent	5,325	38.3%
4 Semi Urgent	5,591	40.2%
5 Non Urgent	2,142	15.4%
Grand Total	**13,903**	**100.0%**
Percent Non-Urgent	7,733	55.6%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care

expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (137319306.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (137319306.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The combination of these projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (137319306.3.1-2) due to enhanced physician-patient relationships and preventive care.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The

relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $690,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $588,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		7,733
% Clinic Appropriate		17%
Clinic Appropriate Patients		1,315
Avg ED Facility Payment	$	550
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**887,874**
Clinic Payment @ 78% savings	$	195,332
Total Estimated Savings	**$**	**692,542**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

137319306.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Crockett			*137319306*
Related Category 3 Outcome Measure(s):	***137319306.3.2***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $463,303	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [387] out of a baseline of 7,733 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $505,438	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [773] out of a baseline of 7,733 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $506,908	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 17% [1,315] out of a baseline of 7,733 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $418,750
Year 2 Estimated Total DSRIP: $463,303	Year 3 Estimated Total DSRIP: $505,438	Year 4 Estimated Total DSRIP: $506,908	Year 5 Estimated Total DSRIP: $418,750
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,894,399***			

Project Option: 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.
Unique Project ID Number: 137921608.2.1 (Pass 3)
Performing Provider Name/TPI: Community Healthcore 137921608

Project Abstract:

Provider: Community Healthcore is a local community mental health center and the local mental health authority with over 400 employees. The center serves nine (9) counties in RHP1 for mental health and is the gateway for individuals in that catchment area that enter the state psychiatric hospital. The center also serves 23 counties with addiction recovery services, both in-patient and out-patient.

Intervention(s): Community Healthcore will collaborate with Good Shepherd Medical Center and the local FQHC in the Longview area to integrate primary and behavioral healthcare services to result in an integrated approach to health care that is "More Than Co-Location." Beginning with coordinated care to include routine screening for behavioral health concerns conducted in primary care settings; primary care screening in behavioral health settings; referral processes to establish co-located services and develop protocols for integrated services located together with a single treatment plan for the target population. Cognitive Behavioral mental health services either face/face or televideo and primary care services will be offered to individuals with co-occurring condition that include uncontrolled hypertension and poor comprehensive diabetes care. When a primary care provider is on-site more time is available to address complex medical issues.

Need for the project: There are no identified primary and behavioral health integrated offices in the local area. Good Shepherd Medical Center and Community Healthcore have seen the need for this integration model related to the number of patients seen in GSMC's emergency department that have psychiatric needs, as well as the individuals seen in Community Healthcore's outpatient clinics with overwhelming primary care needs. Very often these are the same patients, and while this is not a local phenomenon, the impact of care for these individuals can be devastating resulting in a reduced level of care for either primary care, behavioral health care or both. This collaboration is expected to meet the three part aim of CMS and the Regional Anchor's Needs Assessment by lowering costs, improving care for individuals served and improving health outcomes through linked disciplines with behavior change strategies, linked planning and health information.

Target population: The target population for the project will consist of the adults (18 years of age or older) with a serious mental illness (SMI) and diagnosed co-occurring primary care diseases of hypertension or diabetes that live in the Longview, East Texas area.

Category 1 or 2 expected patient benefits: The project will serve 250 adults (baseline) in DY3. Core services to be provided include mental health stabilization, control hypertension and comprehensive diabetes care in co-occurring patients. The project seeks to provide an additional 10% above the baseline in DY4 and 15% above the baseline in DY5.

Category 3 outcomes: OD-1- Primary Care and Chronic Disease Management The project plans to Identify individuals with co-occurring mental illness and primary care needs, specifically those in need of controlling high blood pressure and comprehensive diabetes care: *BP control (<140/80mm Hg)* and provide intervening services. Our goal is to reduce the number of individuals with uncontrolled target conditions by 15% & 20% in DY4 and DY5 respectively.

Project Narrative

Brief Description/Delivery System Solution

Community Healthcore in partnership with Good Shepherd Medical Center and Genesis PrimeCare (East Texas regional FQHC), will develop and implement an integrated primary/behavioral health center located at 1300 North 6th Street. This location provides central proximity to key partner administrative locations as well as other community agencies and specialties integral to its function. Organization and provider agreements will be established including necessary legal agreements to facilitate a common protocol for comprehensive integrated screening and service delivery. Agreements and protocols will also include essential speciality functions including but not limited to emergency psychiatric care, addiction screening and recovery, cardiac screening and care, nutrition, diabetes, and weight loss. Coordination of care will be managed through utility of trained specialists in multidisciplinary community based care workers within a centralized medical home model. Protocols established for communication, electronic data sharing, and co-scheduling will also be centralized function managed by care coordination specialists. All participating providers and support staff will be trained in integrated health protocols toward creation of a culture of comprehensive care over co-location and referral. Data sharing and co-scheduling will be accomplished by utililization of a common electronic medical record (EMR) integrating existing EMR software and equipment through a common centralized portal. Care coordination specialists will operate as team coordinators to facilitate development and implementation of an integrated health care plan, organize regular consultative meetings between primary care and behavioral health professionals, and organize case conferences between all key providers including specialists as needed and appropriate. Data collected through integrated health records will be managed in a common format to facilitate reporting and quality improvement. All healthcare partners participating in this project will be represented on a rapid cycle change team (RCCT) that will routinely evaluate protocols, service delivery, outcomes, and best practices. The RCCT will collaborate with the University of Texas Health Science Center-Tyler in a college of lessons learned in conjunction with five other regional hospitals with solidify positive gains and provide an avenue for substantive change as the project develops.and establish a “lessons learned” format for review as well as implementation of evidence based practice into staff training and an ongoing protocol improvement process.

~~Implement primary/behavioral care integration with Good Shepherd Medical Center, the local FQHC and Community Healthcore’s clinic settings by facilitated mental health and general health policies in the organizations that emphasize mental health services at primary care levels. Mental health/primary care integration in this model involves a culture change beyond co-location and collaboration as a deliberate and strategic process of comprehensive care delivery.~~ This project will target estimates of the prevalence of mental disorders, and the burden they impose if left untreated to support the need for an integrated medical home model. This delivery system solution will include use of telemedicine technologies to enhance the reach of services to remote locations as well as immediacy in local emergency departments with the overall aim to increase access, improve care, and reduce the cost burden in emergency departments. Adequate training of primary care workers on mental health issues is an essential prerequisite for mental health integration. Training on doable tasks within limited time frames and seeking appropriate consultation with behavioral health that are available at the right times keeps primary care workers functioning best. ~~Collaborate with the University of Texas Health Science Center-Tyler in a college of lessons learned in conjunction with five other regional hospitals with solidify positive gains and provide an avenue for substantive change as the project develops.~~

Goal(s):

Project Goal: Integrate primary care and behavioral health care services in order to improve care and access to needed services because the burden of mental disorders is great and mental and physical health problems are interwoven. .

Starting Point/Baseline:

As a determinate of baseline activity Community Healthcore estimates than in Waiver Demonstration year three (DY3) 250 individuals diagnosed with hypertension and/or diabetes will be served through the Integrate Physical and Behavioral Health Care project and serve as a baseline. Controlling hypertension is an important step in preventing cardiovascular disease. Interventions to lower blood pressure and comprehensive diabetes care can be an effective way to improve longevity and other health outcomes.

Rationale:

By evaluating and developing a primary care-behavioral integration pilot benefits to the individuals and communities will be realized through improved planning by better use of data resulting in evidenced and informed interventions. These activities promote a framework to improve health of individuals will result in primary and tertiary disease prevention. Because disciplines will be linked through the integrations planning, health information and behavior change strategies will demonstrate a better outcome for individuals needing these combined services. Data from Cherokee Health Systems in Tennessee and other systems suggest that integrating primary care and mental health care saves 20 percent in health care costs.

The National Council for Community Behavioral Healthcare consultants and external reviewers has supported a Four Quadrant Model approach for primary and behavioral health integration. Evidence based practice guidelines that are diagnosis/condition specific and a Four Quadrant Model approach as a conceptual model of behavioral health and healthcare services will provide a template for local resource consideration and developing alternative methods (telemedicine, etc.) of coordination that may be required when specialty care is delivered in this rural regional.

Challenges/Community Need and How the project is related to the regional goals: CN.1, CN.2, CN.4, CN.5

Few mental health providers are trained to work in the primary care setting and neither primary care nor mental health physicians are trained to work as a primary care team. Therefore, local hospital emergency departments continue to face challenges of treating individuals in their most expensive setting for non-emergency illnesses. This is not a local phenomenon. Psychiatric hospitals found that 20% of adults discharged had chronic and serious physical conditions, and 75% with a diagnosis of schizophrenia. Similarly, national studies indicate that nearly 65% of rural residents receive mental health services from their primary care physician and most are treated with pharmacological services rather than comprehensive disease management or recovery protocols. Consistent connection to integrated behavioral health and primary care is projected to reduce ER visits: *in a project pilot, ER visits dropped 20%*. Engagement of community health workers through primary care/behavioral health integration within the medical community would help alleviate this burden.

Expected Outcome:

By evaluating and developing a primary care-behavioral integration pilot benefits to the individuals and communities will be realized through improved planning by better use of data resulting in evidenced and informed interventions. These activities to promote a framework to improve health of individuals will result in primary and tertiary disease prevention. Because disciplines will be linked through the

integrations planning, health information and behavior change strategies will demonstrate a better outcome for individuals needing these combined services. Additionally with the reduction in individuals seeking primary care in the emergency departments it is expected that the integrated care project with reduce costs.

Related Category 3 Outcome Measure(s):

High blood pressure (hypertension) is an important risk factor for the development and worsening of many complications of diabetes, including diabetic eye disease and kidney disease. Most people with diabetes develop high blood pressure during their life. Individuals with mental illness do not seek primary care regularly, and when they do it is typically through the emergency department. Hypertension and diabetes increases the risk of developing other cardiovascular problems, because diabetes adversely affects the arteries, predisposing them to atherosclerosis (hardening of the arteries). Atherosclerosis can cause high blood pressure, which if not treated, can lead to blood vessel damage, stroke, heart failure, heart attack, or kidney failure.

OD-1- Primary Care and Chronic Disease Management

- IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)228 *(Standalone measure)*
- IT-1.11 Diabetes care: *BP control (<140/80mm Hg)234 – NQF* 0061 *(Standalone measure)*

Relationship to other Projects:

This project will assist in **1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization** by appropriate referrals from ED's and the Crisis Center keeping primary care settings able to appropriately **1.1.2 Expand Primary Care Capacity** without the extended time in dealing with individuals that need a stable location apart from the ED or primary care physician office. The RCRC will assist in **1.9.2 Improve Access to Specialty Care** through a specific location for emergency crisis response and thereby relieve local psychiatrists offices from community crisis response. The RCRC will also **2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting.** It will support **2.13.1 - Jail Diversion Expansion** by providing early intervention and appropriate referrals to the criminal justice system. It could further support **2.9.1- Patient Care Navigation Services** by assisting in care navigation support for frequent ED users. This would no doubt aid in **2.4 Redesign to Improve Patient Experience.**

Relationship to Other Performing Providers' Projects in the RHP:

- Good Shepherd Medical Center-Longview

Plan for Learning Collaborative:

A "lessons learned" action will be engaged with the University of Texas Health Science Center-Tyler to dynamically engage academics, Community Healthcore TQM staff in a community based research to explore learning and ethical underpinnings of this project. The Lessons Learned effort will focus in part on "myths", such as specialized services are "better", and that training occurs not only through formal training but beyond the degrees and diplomas through ongoing informal interactions with health specialists. A plan for Rapid Cycle Change and development of a Team to collect data, develop the "college of lessons learned" for use in continuous quality improvement and participation with UTHSC-T cooperative with 5 regional hospitals. Date TBD.

Project Valuation:

Valuation of the project included cost avoidance with a reduction in admissions to the hospital through the emergency department (the most expensive care for the hospital) for both non-emergency primary care and psychiatric related illnesses would result costs reductions for hospitals and engage individuals in a medical home by treating “the right care at the right time in the right setting.” An expected reduction of admissions to the state hospital will be achieved through wrap around services and keeping individuals in the community appropriately and preventing loss of work productivity for long periods of absence from the community. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

~~[Unique Category 2 Project Identifier, e.g. Project [TPI].1.1]~~ **137921608.2.1**	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 2.15.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 2.15.1.A.B.C.D.E.G.H.I.J.	Integrated Care: "More Than Co-Location"
Community Healthcore			137921608
Related Category 3 Outcome Measure(s): ~~**137921608.3.3**~~ **137921608.3.4**	~~[unique Category 3 IT identifier(s)]~~ **3.IT-1.7, ~~IT-1.9,~~ IT-1.11**	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ **OD-1- Primary Care and Chronic Disease Management**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestones8 **Milestone 1** [P-1] **P-1 Milestone: Conduct needs assessment to determine areas of the region where the collocation of services has the potential to benefit a significant number of people who have physical/behavioral health needs.** Metric 1 P-1.1 Numbers of patients in various areas who might benefit from integrated services. Demographics, location, & diagnoses ***ta 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* Milestone 1 Estimated Incentive	**Process Milestones** **Milestone 4** [P-6] **P-6 Milestone: Develop integrated behavioral health and primary care services within co-located sites.** Metric 4 P-6.1 ***Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).*** ***Data Source**: Project data.* ~~***P-6.2. Metric: Number of providers achieving Level 5 of interaction (close collaboration in a partially integrated system).***~~ ***Data Source**: Project data.* Milestone 4 Estimated Incentive Payment *(maximum amount):* $47,409	**Improvement Milestones** **Milestone 7** *I-8. Milestone: Integrated Services* Metric 7 I-8.1. Increase of individuals receiving both physical and behavioral health care at the established locations over baseline. ***Baseline/Goal:** increase by 10% individuals receiving physical and behavioral care.* ***Data Source**: Project data; claims and encounter data; medical records* Milestone 7 Estimated Incentive Payment *(maximum amount):* $77,953 **Milestone 8** *I-10. Milestone: No-Show Appointments* Metric 9 I-10.1.	**Improvement Milestones** **Milestone 9** *I-8. Milestone: Integrated Services* Metric 9 I-8.1 Increase of individuals receiving both physical and behavioral health care at the established locations over baseline. ***Baseline/Goal:** increase by 15% individuals receiving physical and behavioral care.* ***Data Source**: Project data; claims and encounter data; medical records* Milestone 9 Estimated Incentive Payment *(maximum amount):* $85,813 **Milestone 10** *I-10. Milestone: Coordination of Care* Metric 10 I-10.1

~~[Unique Category 2 Project Identifier, e.g. Project [TPI].1.1]~~ **137921608.2.1**	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 2.15.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 2.15.1.A.B.C.D.E.G.H.I.J.	Integrated Care: "More Than Co-Location"
Community Healthcore			137921608
Related Category 3 Outcome Measure(s): ~~**137921608.3.3**~~ **137921608.3.4**	~~[unique Category 3 IT identifier(s)]~~ **3.IT-1.7, ~~IT-1.9,~~ IT-1.11**	~~[Reference number(s) from RHP PP]~~ P-1,P-2,P-4,	~~[Outcome Measure (Improvement Target) Title(s)]~~ **OD-1- Primary Care and Chronic Disease Management**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment *(maximum amount):* $39,460 **Milestone 2** [P-2] P-2. Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings, or for physicians to share their office space with behavioral health practitioners. Metric 2 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. ***Data Source**: Information from persons interviewed* Milestone 2 Estimated Incentive	**Improvement Milestones** **Milestone 5** *I-8. Milestone: Integrated Services* Metric 5 I-8.1. Metric: Serve baseline estimate, 250 individuals annually, prorated for partial year DY3 of 62. ***Data Source**: Project data; claims and encounter data; medical records* Milestone 5 Estimated Incentive Payment *(maximum amount):* $47,409 **Milestone 6** *I-10. Milestone: No-Show Appointments* Metric 6 I-10.1 Decrease of the "no shows" for behavioral and physical health appointments.	Decrease of the "no shows" for behavioral and physical health appointments. ***Baseline/Goal:** Decrease "no shows" by 12% individuals receiving physical and behavioral care.* ***Data Source**: Project data; claims and encounter data; medical records* ***Data Source**: Project data; Clinic Registry Data; claims and encounter data;* Milestone 9 Estimated Incentive Payment *(maximum amount):* $77,953	Decrease of the "no shows" for behavioral and physical health appointments. ***Baseline/Goal:** Decrease "no shows" by 15% individuals receiving physical and behavioral care.* ***Data Source**: Project data; Clinic Registry Data; claims and encounter data;* Milestone 10 Estimated Incentive Payment *(maximum amount):* $85,813

~~[Unique Category 2 Project Identifier, e.g. Project [TPI].1.1]~~ **137921608.2.1**	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 2.15.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 2.15.1.A.B.C.D.E.G.H.I.J.	Integrated Care: "More Than Co-Location"
Community Healthcore			137921608
Related Category 3 Outcome Measure(s): ~~**137921608.3.3**~~ **137921608.3.4**	*~~[unique Category 3 IT identifier(s)]~~* **3.IT-1.7, ~~IT-1.9,~~ IT-1.11**	*~~[Reference number(s) from RHP PP]~~* P-1,P-2,P-4,	*~~[Outcome Measure (Improvement Target) Title(s)]~~* **OD-1- Primary Care and Chronic Disease Management**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Payment *(maximum amount):* $39,460 **Milestone 3:** [P-3] P-3 Milestone: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. Metric 3 P-3.1 ***Number and types of referrals that are made between providers at the location*** ***Data Source**: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results.* ~~***P-3.2 Metric: Number made outside of the location***~~ ~~*a. Data Source: Surveys of providers to determine the degree*~~	***Baseline/Goal:** Decrease "no shows" by 12% individuals receiving physical and behavioral care.* ***Data Source**: Project data; Clinic Registry Data; claims and encounter data;* Milestone 6 Estimated Incentive Payment *(maximum amount):* $47,409		

~~[Unique Category 2 Project Identifier, e.g. Project [TPI].1.1]~~ **137921608.2.1**	~~[Reference number of Project Option from RHP PP – e.g. 1.X.X]~~ 2.15.1	~~[Reference Number of Project Component(s) from RHP PP – e.g. 1.X.X.X]~~ 2.15.1.A.B.C.D.E.G.H.I.J.	Integrated Care: "More Than Co-Location"
Community Healthcore			137921608
Related Category 3 Outcome Measure(s): ~~**137921608.3.3**~~ **137921608.3.4**	*~~[unique Category 3 IT identifier(s)]~~* **3.IT-1.7, ~~IT-1.9,~~ IT-1.11**	*~~[Reference number(s) from RHP PP]~~* P-1,P-2,P-4,	*~~[Outcome Measure (Improvement Target) Title(s)]~~* **OD-1- Primary Care and Chronic Disease Management**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
~~*and quality of information sharing; Review of referral data and survey results.*~~ ~~***P-3.3 Metric: Number of referrals which follow the established standards.***~~ ~~*a. Data Source: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results.*~~ Milestone 3 Estimated Incentive Payment *(maximum amount):* $39,460			
Year 2 Estimated Milestone Bundle Amount: $118,379	Year 3 Estimated Milestone Bundle Amount: $142,226	Year 4 Estimated Milestone Bundle Amount: $155,906	Year 5 Estimated Milestone Bundle Amount: $171,625
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $588,137			

Project Option: 2.6.2 – Establish self-management programs and wellness using evidence-based designs.
Unique Project ID Number: 138360606.2.1
Performing Provider Name/TPI: Northeast Texas Public Health District 138360606

Project Abstract

Project Description: The Vision of the Northeast Texas Public Health District (NET Health) is *through our collaborative efforts, Northeast Texas communities will be the healthiest in the State.* Our Mission is *to prevent illness, promote health, and protect our community.* NET Health exists to make Tyler a healthier community. Every resident is affected by our services DAILY. If you live or work in Tyler, NET Health serves its citizens daily through milk and water testing, food and restaurant inspections, animal and mosquito control, disease surveillance, immunization against diseases, and preparation for "manmade" or natural disasters. In addition, NETPHD has WIC (Women, Infants, and Children) Program, Public Health Emergency Preparedness, Breast and Cervical Cancer Screening Services and Community Transformation programs. The Northeast Texas Public Health District (NET Health) is the public health authority for Smith County and utilizes assessment data from multiple sources to identify health issues and disparities within the county. Through this proposal, NET Health is proposing a Center for Healthy Living, project 138360606.2.1.

The Center for Healthy Living will focus on improving the quality of life of citizens of Tyler. Health education will be provided including: diabetic management classes, tobacco cessation programs, nutrition counseling, access to WIC and immunization services, health coaching and health education media campaigns. Screenings such as mobile mammography, blood pressure, blood glucose, cholesterol, weight and BMI will be provided, through partnerships with other performing providers in Region 1, as outlined and selected as project option 2.6.2. This project option was selected to bridge the gap between prevention and primary healthcare for the uninsured and underserved population that does not otherwise have access to services. The selection of this project was based on the recommendation of self-management programs, such as the diabetes management program recommended by the Community Preventive Services Task Force.
[1] http://www.thecommunityguide.org/healthcommunication/campaigns.html
[2] http://www.thecommunityguide.org/diabetes/diseasemgmt.html

Goal: The overall project goal of strategy 2.6 is to implement innovative evidence based health promotion strategies such as use of community health workers, innovations in social media and messaging for targeted populations and the following goals would be specifically addressed through the creation of this center:

- Identification of Community Health Disparities in the targeted St. Louis Community and throughout the population of Tyler.
- Implementation of chronic disease self-management programs
- Providing access to screenings for individuals to manage chronic diseases

- Increased access to WIC and Immunization services to the City of Tyler.
- Increase in health literacy and knowledge regarding health issues

This proposed project directly addresses an increase in access to healthy living services, prevention and screening programs and chronic disease self-management, which those that are uninsured or underinsured don't otherwise have access to. The primary challenge for NET Health as the performing provider is the limited access to resources for clinical services for the uninsured population in Tyler. Currently, there is one FQHC for all of the uninsured clients in Smith County, however since they are the only resource the demand is very high and getting the population into an established primary care setting will be a barrier. Other potential challenges and barriers for the performing provider and the clients they serve are identified as accessible public transport to health resources, access to health foods, and safe environments for physical activity. This program would address the issues of access to healthcare for the low-income, uninsured community as well as identifying and eliminating health disparities by creating strong partnerships with the FQHC and other low cost clinics in the area to establish a primary care referral relationship. These challenges will be also be addressed by creating a center for healthy living, that provides credible prevention information and screenings that the citizens cannot otherwise access, in the heart of this community and by making it "citizen-friendly." After 5 years, the citizens of Tyler will have an improved quality of life and be able to take charge of their own health status and view NET Health as an integral part of the community structure and as a credible source of health information. This project could potentially help lower the number of preventable hospitalizations as well as reduce health care costs for our region.

The project implementation plan, outlined in the attached milestone tables, include the following:

1. Needs Assessment, collection of baseline data, and strategy and priority planning.
2. Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community
3. Implement, document and test evidence-based project for the targeted population
4. Evaluation of program to determine increases in baseline data and increases in access to health promotion programs

Quality improvement of both project 2.6.2 will utilize the NET Health established quarterly QA/PI policy to evaluate the programs and report quarterly, as well as an annual NET Health strategic planning session which utilizes a SWOT analysis. The process through which the programs are reviewed for quality improvement measures will be a PDSA model. Logic Model will be developed for both project 2.6.2. Quarterly examination of models, program participants, program impacts, and challenges and barriers will be addressed.

The Community Needs Assessment, included in the RHP for Region 1 as identification numbers CN.3 and CN.4, outlines the following highlighted health disparities which are the basis of the development of the Center for Healthy Living Project.

- Blood Pressure: "The Department of State Health Services estimates that 43.1% of the African American Population in East Texas has high blood pressure compared to 33.9% of African Americans in Texas. DSHS also estimates that 32.4% of the White/Caucasian population in East Texas has high blood pressure compared to 28.2% of the White/Caucasian population in Texas."
- Cholesterol: "East Texas has significantly lower rates of cholesterol screening than statewide averages."

The targeted demographic for the purposes of this project is the City of Tyler and more specifically the St. Louis neighborhood in which the Center for Healthy Living would be located. As identified in the City of Tyler's *Tyler 21 Plan*, the location of the St. Louis community has a high density of residents of which 51%-100% of its residents are African American and the average annual income is between $14,152 - $33,107, which is lower than the average for Smith County. According to the Tyler Economic Development Council, the City of Tyler has a population of 96,900 individuals, 60.5% being White, 24.7% Black and 21.1% Hispanic/Latino. 25% of adults in Smith County are uninsured and 16.2% of all Smith County citizens are living in poverty, according to statistics by the Texas Department of State Health Services. Approximately 15 % of the population speaks a language other than English at home and 13% of the County's population is considered illiterate. Both of these factors make communication of healthy behavior messages difficult to achieve on a general level. Smith County has had a 20% increase in population between 2000 & 2010, matching the Texas growth rate. It has 26% of the population under age 18 and 16% are 65 or older. By the most recent profile information (2010), 16% of the population lives in poverty but 25% of children under age 18 live in poverty. 51% of the population is female with the racial and ethnic mix of Smith County being 70% Caucasian, 18% African-American, and 17% Hispanic. The per-capita income in Smith County in 2009 was $36,456, which is slightly lower than the state level. In 2009 the poverty level for the county was 16%, close to the state average. Between 2006 and 2010 the unemployment rate increased from 4.7% to 7.9%. Major employment areas are health care services, oil and gas industry, and two major manufacturers. Both of these major manufacturers have laid-off workers and announced moving. Smith County has a geographic area of 950 square miles. There are rural areas as well as 11 incorporated communities. It is the most populous county in Northeast Texas, having a population of approximately 210,000. Half of that population lives in Tyler, which is the county seat, with other incorporated areas also ranging in size from 600 to 8,000.

This project will be a start-up program. Therefore, our current number of clients served by this project is 0. The goal for this project is to see a minimum of 250 individuals for at least one of the services outlined above, during the first year and increase to 500 individuals served by DY5. Each self-management class offered will have a minimum of 10 participants and the volume of outlined screenings is projected at 100 annually and will increase based the number of participants. On staff, NET Health currently has 6 Certified Community Health Workers and 1 Certified Health Education Specialist. All 7 of these staff members are trained on helping people improve their health through self-management techniques. For this specific project, we propose to employ at least one Community Health Worker, possibly a nurse and Program

Director dedicated solely to this site. Baseline data will be collected during DY2. Texas Health Institute is currently compiling a community needs assessment for Smith County. The data from this needs assessment can also be used as part of the baseline data.

Tyler does not have any kind of health education resource center for the community to use with no cost. Therefore, project 2.6.2 was selected and will open up many opportunities for the underserved populations in Tyler to take control of their own health and become educated on how to improve their quality of life. The targeted ailments will include cardiovascular disease and the use of tobacco. In 2009, Tyler MSA had a lung cancer rate of 57.4 as compared to the State's rate at 45.7. In 2007, Smith County – which is largely populated by the city of Tyler – had a cardiovascular disease prevalence of 15.2%, which is almost double the State's prevalence of 8.3% (Texas Department of State Health Services). These statistics alone show the immense need for a program that teaches our citizens to control their own health through primary and secondary prevention, and if needed, tertiary prevention. From 2005 – 2010, Smith County had $134,966,405 in preventable hospitalizations as it relates to Congestive Heart Failure, $18,181,713 related to High Blood Pressure and $18,733,608 in Diabetes short-term care. According to the DSHS, "Communities can potentially prevent hospitalizations by encouraging an increased level of aerobic physical activity, maintaining a healthy weight, limiting the consumption of alcohol to moderate levels for those who drink, reducing salt and sodium intake, and eating a reduced-fat diet high in fruits, vegetables, and low-fat dairy food" (Texas Department of State Health Services, 2012). County Health Status Indictors: Recent health data from the County Health Rankings 2011 has Smith County with a 22% rate of adult smokers vs. the national benchmark of 15%. The adult obesity rate is 28% vs the national benchmark of 25%. In 2008 the rate of high blood pressure among African-Americans in Smith County was 43% vs. the rate of 20% in the general Texas population. All of these lead to significant health issues among specific segments of our county population. For the impact of elevated cholesterol in the adult population, the most recent data (2008) estimates that 83% of Hispanics, 45% of African-Americans and 28% of Caucasians had not had their cholesterol level checked in the previous 5 years. In addition, within the county it is estimated that at least 25% of the population have inadequate social support related to health issues. In the most recent County Health Rankings, only 56% of the population identified access to healthy foods. Full-service supermarkets are, there is very limited public transportation, and the costs of foods are all factors in this issue. Another health related issue is the perceived limited access to recreational facilities. While there are health clubs or recreational facilities throughout the county, most have a set membership fee and are not geographically accessible to most low-income neighborhoods.

For the project 2.6.2 the stand-alone outcome measure selected is OD-10, Quality of Life/ Functional Status, IT-10.1 Quality of Life. This outcome measure will be used to demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for our target population. The five-year expected outcome for the projec 2.6.2 is to show an increase in the reported Quality of Life, AQoL – 8D scores in 20% of participants that access services. The tool was selected based on the educational and

community-based programs outlined in the "Healthy People 2020: 2020 Topics & Objectives" and how the educational and community-based programs enhance quality of life.[3]

Project Valuation: The estimated local funding to support the project is approximately $66,000. Based on the estimated local funding available, the majority of DY 2 funding will be utilized to assess the need, establish baseline date and perform priority planning. Estimated incentive payments for DY 2 are based on projected expenses of hiring a proposed three positions: Director/Manager, Nurse, and Community Health Worker. It also includes basic expenses of screening supplies and some overhead cost. The proposed incentive payment will not cover the total cost of operations of the Center for Healthy Living and therefore, NET Health will utilize previously established community partnerships to conduct programming, utilize existing departments within NET Health and train members of the targeted community.

[3] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=11.

DY3 shows an increase in valuation for implementation of programing based on DY 2 established need. Due to the establishment of staffing in DY 2, DY 3 estimated incentive is for participant recruitment and program implementation as well as screening supplies and health education funding. DY4 will mimic DY3 and DY5 funding is lowered and will focus on Evaluation of programs.

138360606.2.1	*2.6.2*		***CENTER FOR HEALTHY LIVING – ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS.***
NORTHEAST TEXAS PUBLIC HEALTH DISTRICT			**1383606-06**
Related Category 3 Outcome Measure(s): *OD-10 Quality of Life*	138360606.3.1	*IT-10.1*	Five-year outcome is to increase AQoL-8D scores in 20% of the program participants

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*RHP PP Milestone* – P-2]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. Metric 1 [P-2.1]: Document innovational strategy and plan Baseline/Goal: Collection of baseline Data through Community Health Needs Assessment. Data Source: Performing Provider evidence of innovational plan through conducting community health needs assessment Milestone 1 Estimated Incentive Payment (*maximum amount)*: $158,000	**Milestone 2** [P-3]: Implement, document and test an evidence-based innovative project for targeted population Metric 1 [P-3.1]: Document implementation strategy and testing outcomes. Baseline/Goal: Increase participants in program by 5% Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider, Program Participation – Baseline data collected during DY2 Milestone 2 Estimated Incentive Payment (*maximum amount)*: $66,000 **Milestone 3** [P-6]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-6.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participates in. Baseline/Goal: Data Source: Documentation of	**Milestone 4** [P-3]: Implement, document and test an evidence-based innovative project for targeted population Metric 1 [P-3.1]: Document implementation strategy and testing outcomes. Baseline/Goal: Increase participants in program by 5% Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider, Program Participation – Baseline data collected during DY2 Milestone 4 Estimated Incentive Payment (*maximum amount)*: $66,000 **Milestone 5** [P-5]: Execution of evaluation process for project innovation. Metric 1 [P-5.1]: Document evaluation process tools and analytics. Baseline/Goal: Begin the evaluation process to determine increases in baseline data collected in DY2 & DY3 Data Source: Performing Provider	**Milestone 6** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached. Goal: To increase by 10 percent of target population served by program, above the baseline data collected in DY2 Data Source: Documentation of target population reached as designated in the project plan. Milestone 6 Estimated Incentive Payment: $110,000

138360606.2.1	***2.6.2***		***CENTER FOR HEALTHY LIVING – ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS.***	
NORTHEAST TEXAS PUBLIC HEALTH DISTRICT				**1383606-06**
Related Category 3 Outcome Measure(s): *OD-10 Quality of Life*	138360606.3.1	*IT-10.1*	Five-year outcome is to increase AQoL-8D scores in 20% of the program participants	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides and meeting notes. Milestone 3 Estimated Incentive Payment: $66,000		contract or other documentation of implementation TBD by performing Provider Milestone 4 Estimated Incentive Payment (*maximum amount)*: $66,000	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 158,000	Year 3 Estimated Milestone Bundle Amount: $ 132,000		Year 4 Estimated Milestone Bundle Amount: $ 132,000	Year 5 Estimated Milestone Bundle Amount: $110,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5): $532,000*				

Project Option: 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the criminal justice system
Unique Project ID Number: 138365512.2.1 (Pass 1)
Performing Provider Name/TPI: Andrews Center 138365512

Project Abstract

Provider Description: Andrews Center Behavioral Healthcare System is a non-profit, comprehensive mental health and mental retardation center. Services are provided in a five-county area of Northeast Texas (Smith, Wood, Rains, Van Zandt and Henderson) with an estimated population of 390,014.

Intervention: This project will implement a jail diversion program to intercept behavioral health patients from several points within the justice system and move them to a system geared to dealing with their behavioral health needs, thus avoiding overuse of the resources within the justice system in Northeast Texas.

Need for the Project: The jail is inappropriately used as a treatment facility for behavioral health offenders. Providing jail diversion services will intercept behavioral health patients from the justice system and prevent offenders with SPMI from decompensating and requiring long-term forensic commitments, often longer than 120 days. The community needs assessment also cites insufficient access to behavioral care services (CN.2).

Target Population: The target population is behavioral health patients at-risk for entering the criminal justice system. We anticipate serving approximately 75 patients per year with a Medicaid and indigent population of at least 55%.

Category 1 or 2 Expected Patient Benefits: The jail diversion program estimates a baseline of 50% (37 individuals) for DY3 will demonstrate improved functional status on standardized instruments. We will gather data to validate or improve this baseline estimate. The project seeks to realize a 5% increase over baseline in the number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments by DY4 and improvement of 10% over baseline in DY5. This equates to 4 and 8 individuals in DY4 and DY5 respectively. Patients will benefit from increased access to behavioral health services and a decreased recidivism rate.

Category 3 Outcomes: The jail diversion project (138365512.2.1) will decrease mental health admissions and readmissions to criminal justice settings such as jails or prisons (*3.IT-9.1)*. Andrews Center plans to decrease mental health admissions and readmissions to criminal justice settings by 5% and 10% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: The Andrews Center is proposing to intercept behavioral health patients from several points within the justice system and move them to a system geared to dealing with their behavioral health needs, thus avoiding overuse of the resources within the justice system in Northeast Texas. We anticipate serving 75 patients per year, and estimate a baseline success rate of 50% (37 individuals) as measure by improved scores on standardized instruments. Our goal is to increase the number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments by 5% over baseline in DY4 and 10% in DY 5.

Consistent with the overarching goal and vision of RHP 1, Andrews Center is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of Andrews Center. Northeast Texas is an area where patients face many challenges in accessing primary, specialty, and behavioral health care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, Andrews Center is proposing to intercept behavioral health patients from several points within the justice system to address the identified gaps in the current behavioral health and justice systems. Expanding behavioral health care access with jail diversion services meets several community needs outlined by RHP 1, including: insufficient access to behavioral care services (CN.2), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

Modeled after the Sequential Intercept Model, the Andrews Center Jail Diversion expansion project will include identification and engagement of the behavioral health at-risk population among every intercept in the criminal justice system – from pre-trial diversion to re-entry from jail and prison. This will include screening, psychiatric services, therapy, peer services, psychotropic medications, and intensive case management based upon the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) model of service delivery. In conjunction with a Special Needs Supervision Officer, the consumer will receive individualized treatment which may include Forensic Assertive Community Treatment, Supportive Housing, Supportive Employment, Co-Occurring Psychiatric and Substance Use Disorders training, and the like. Within a newly formed Mental Health Court and Drug Court our Local Mental Health Authority Caseworker(s) will facilitate early identification of offenders for jail diversion and treatment of substance use disorders (SUD's). Also, the project will include education of the community and law enforcement officers (LEO). This project will include the use of evidence based practices such as motivational interviewing, and trauma informed care. Focused on dynamic criminogenic risk factors, psychosocial rehabilitation will be individualized for each participant. Treatment will be community based with early identification measures in the correctional facility.

Andrews Center will design community-based specialized interventions for behavioral health patients in the criminal justice system, including:

- Specialized behavioral therapies
- Prescription medications
- Peer support
- Substance abuse services

The Andrews Center will need to hire 4 caseworkers, 1 licensed clinical staff member, 1 court coordinator, and one administrative support staff to intercept behavioral health patients from several points within the justice system.

Other specific project components include the following: assess size, characteristics and needs of target population; review literature with populations similar to target population to determine community based interventions that are effective in averting negative outcomes; develop project evaluation plan using qualitative and quantitative metrics to determine outcomes; design models which include an appropriate range of community based services and residential supports; and assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. These project components will be considered to increase the individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments by 5% over baseline in DY4 and 10% over baseline in DY 5.

Starting Point/Baseline: Andrews Center has a successful collaborative program with one county's probation department for special needs offenders that has a recidivism rate of 13%. According to TCOOMMI research, our 13% recidivism rate is far below the Texas state average of 17.6% for other similar programs, which is even further below the 70% recidivism rate for those offenders with SPMI who receive no treatment at all. We have identified Smith County and Henderson County as having the greatest need for expansion of jail diversion activities due to their significantly higher than average percentage of persons with a behavioral disorder booked into the county jail. Smith County was at 38% and Henderson County was at 43.5% for CY2011. The state average is 27%. Smith County has developed a Criminal Justice Planning Council patterned after Tarrant County's in order to address several issues including mental health. The Smith County Commissioners approved a Mental Health Court several years ago, but it was never initiated due to lack of funding. Smith County also has a Drug Court for family matters and a Veteran's Court for child support matters. The local affiliate of the National Alliance on Mental Illness has prioritized supporting jail diversion efforts; furthermore, Andrews Center has received commendations from the State of Texas for its Jail Diversion Plan. Support for this project has been received by several area courts, directors of probation, incoming sheriff candidates, and Federal Probation.

As an expanded initiative to Smith and Henderson Counties for the Andrews Center, there is currently no easily measured baseline data for jail diversion; therefore, we plan to determine baseline percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments in DY 3. Using comparative analysis

and past professional experience we will estimate a baseline success rate of 50% of persons in the program who will score higher on standardized instruments through this intervention.

Rationale: Currently there is a lack of community resources for those with behavioral health problems involved in the criminal justice system. These include a lack of qualified treatment providers and the encroachment of forensic beds upon civil beds. Along with the stigma of behavioral health disorders, a large number of people with mental illness have a lack of housing, insurance, and employment. Research supports that approximately 70% of persons releasing from prison or jail who have a serious mental illness recidivate within 3 years when they receive no treatment. The Bureau of Justice Statistics estimates that the overall average jail sentence is 6 months, while inmates with a serious and persistent mental illness typically serve 80 days longer.

This project will reduce inappropriate use of the jail as a treatment facility while keeping offenders with SPMI from decompensating and requiring long-term forensic commitments, often longer than 120 days. Forensic commitments are rapidly encroaching on available crisis beds. If crisis beds are not available and community based treatment is inaccessible, the last resort is the criminal justice system. According to the Center for Mental Health Service's National GAINS Center, the Sequential Intercept Model has been used as the gold standard for communities to help organize mental health service system transformation–meeting the needs of people with mental illness involved with the criminal justice system. The model helps to assess where diversion activities may be developed, how institutions can better meet treatment needs, and when to begin activities to facilitate re-entry. Research supports that delivery of comprehensive behavioral health in the community setting, as opposed to the institutional setting, is more effective for long- term community tenure. Implementing this model of jail diversion is proven to reduce the revolving door from homelessness to jail to hospital to prison. As noted in the Region 1 community needs assessment (CN.2), there is a shortage of behavioral health providers. Our jail diversion plan will strive to fill the shortage gap of behavioral health services.

Related Category 3 Outcome Measures: Implementing our evidence-based intervention to keep behavioral health patients out of the justice system will decrease recidivism rates and meet the following community needs: insufficient access to behavioral care services (CN.2), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

The jail diversion project (138365512.2.1) will decrease mental health admissions and readmissions to criminal justice settings such as jails or prisons (*3.IT-9.1)*. The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement of admissions and readmissions to criminal justice settings. Andrews Center plans to decrease mental health admissions and readmissions to criminal justice settings by 5% and 10% in demonstration years 4 and 5, respectively.

The previously stated project description and rationale further describes how implementing the jail diversion program will decrease mental health admissions and readmissions to criminal justice settings.

Relationship to Other Projects: All three of Andrew Center's project plans work together to expand behavioral health services and to prevent potential admissions, readmissions, and ED visits. The first step is to intervene at the ED and appropriately send behavioral health patients to a Regional Crisis Response Centers. These crisis intervention and stabilization centers (138365512.1.1) will more efficiently serve behavioral health needs and get them specialized, cost effective care. Another intervention point is the criminal justice system through our jail diversion program (138365512.2.1). Similar to the crisis stabilization program, our community health workers and criminal justice system stakeholders will work together to keep behavioral health patients out of jail. After crisis stabilization and jail diversion, patients will be guided to the appropriate follow up care in our proposed physical-behavioral health integration program (138365512.2.2). Patients will have access to our psychiatrists and primary care physicians, in order to meet their physical and behavioral health needs. In order to maintain the appropriate follow-up care, Andrews Center has a need to expand outpatient therapy services with 2 new licensed therapists (138365512.2.3).

Relationship to Other Performing Providers' Projects in the RHP: Andrews Center has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of similar projects by Access and Community Healthcore in the RHP. Furthermore, we will participate in learning collaboratives to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: Andrews Center plans to participate in RHP-wide learning collaboratives with other providers with similar jail diversion projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: According to the National Alliance on Mental Illness, Community Behavioral Health is estimated to cost on average $12 per day, whereas incarceration costs approximately $137 per day for those with a mental illness. Hospitalization costs begin around $400 per day, with usage of the emergency room costing around $1,265 per encounter. Inmates with a serious and persistent mental illness (SPMI) typically serve 80 days longer than those without, according to NAMI. Bureau of Justice Statistics lists that the average jail sentence overall is just over 6 months; so inmates with a SPMI on average serve almost 9 months in jail. If we serve 75 offenders with a 17.6% recidivism rate, then we have a valuation of $2.2 Million for prevented inmate costs.

The estimated annual cost savings for the community are shown below:

Estimated Annual Savings Sequential Intercept Model	
Behavioral Health Offenders Served	75
Recidivism Rate	17.6%
Offenders Prevented Jail Re-entry	**62**
Days in Jail per Offender	260
Jail Re-entry Days Prevented	**16,068**
Cost of Inmate w/SMI per Day	$ 137
Estimated Annual Savings	**$2,201,316**

***138365512*.2.1**	***2.13.1***	***2.13.1.A-E***	**Interventions tailored towards individuals in the criminal justice system**
Andrews Center			***138365512***
Related Category 3 Outcome Measure(s):	***138365512*.3.2**	*3.IT-9.1*	*Mental health admissions and readmissions to criminal justice settings*

Year 2	Year 3	Year 4	Year 5
Milestone 1: P-2 Design community-based specialized interventions for behavioral health patients in the criminal justice system, including: • Specialized behavioral therapies • Prescription medications • Peer support • Substance abuse services **Metric: P-2.1** Project plans which are based on evidence / experience and which address the project goals **Baseline/Goal:** Project Documentation **Data Source**: Project plans and documentation	**Milestone 2: I-5** Functional Status **Metric: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** Determine actual baseline percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments versus estimate of 50%(37 individuals) **Data Source:** Standardized functional assessment instruments (e.g. GAF, ANSA, CANS, etc.)	**Milestone 3: I-5** Further improvement in Functional Status per metrics below: **Metric 1: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 2.5% (39 patients) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Mar 31, 2015. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments **Metric 2: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 5% (41 patients) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Sept 30, 2015. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments	**Milestone 4: I-5** Further improvement in Functional Status per below: **Metric 1: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 7.5% (43 patients) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Mar 31, 2016. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments **Metric 2: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 10% (45 patients) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Sept 30, 2016. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments
Milestone 1 Est Incentive Payment: $656,957	**Milestone 2 Estimated Incentive Payment:** $721,460	**Milestone 3 Estimated Incentive Payment:** $ 771,778	**Milestone 4 Estimated Incentive Payment:** $ 745,682
Year 2 Estimated Total DSRIP Funding: $656,957	Year 3 Estimated Total DSRIP Funding: $721,460	Year 4 Estimated Total DSRIP Funding: $771,778	Year 5 Estimated Total DSRIP Funding: $745,682

TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* $ ***2,895,877***

Project Option: 2.15.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services
Unique Project ID Number: 138365512.2.2 (Pass 1)
Performing Provider Name/TPI: Andrews Center 138365512

Project Abstract

Provider Description: Andrews Center Behavioral Healthcare System is a non-profit, comprehensive mental health and mental retardation center. Services are provided in a five-county area of Northeast Texas (Smith, Wood, Rains, Van Zandt and Henderson) with an estimated population of 390,014.

Intervention: This project will improve the integration of behavioral health and primary care services at various potential locations in Region 1, primarily through primary care clinic services in the behavioral health setting.

Need for the Project: Approximately 45% of Andrews Center's overall adult patient population has no primary care physician. The majority of our patients reside in Smith County where the percentage of adult patients without a primary care physician rises to 64%. Given the low economic status of this population, these individuals face many barriers to primary health care. The community needs assessment cites insufficient access to behavioral care services (CN.2), high rates of chronic disease (CN.3), high costs of potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

Target Population: The target population is behavioral health patients in need of physical, primary care services. Based on FY2012 data we anticipate a yearly pool of 1,878 Smith County adult behavioral health patients, of which approximately 1,202 (64%) have no primary care physician.. We plan to serve approximately 563 (30%) of these 1,878 potential patients by DY5, with a Medicaid and indigent population of at least 55%.

Category 1 or 2 Expected Patient Benefits: The primary and behavioral health integration project seeks to serve at least 188 (10%) of the patient pool by the end of DY 3, 376 (20%) by the end of DY 4. By the end of DY 5 our service goal is 563 (30%) of the 1,878 Smith County adult behavioral health patients. These behavioral health patients will benefit from increased access to primary care services.

Category 3 Outcomes: The primary and behavioral health integration project will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients (IT-9.2). Andrews Center plans to decrease ED visits for patients receiving interventions through primary and behavioral care integration by 10% and 15% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: The Andrews Center will design, implement, and evaluate projects that provide integrated primary and behavioral health care services with a goal of 30% of the 1,878 adult Smith County behavioral health patients receiving physical and behavioral care through this program. In FY2012 the Andrews Center treated approximately 6,300 adults throughout its entire 5 county service area; this project however will focus on Smith County. Smith County accounts for 15.8% of the total RHP 1 population and represents 44% of the behavioral health need in Andrews Center's service area.

Our chosen implementation strategy will include the following:

- Assure regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all individuals receiving psychotropic medications – check glucose and lipid levels, as well as blood pressure and weight/BMI, record and track changes and response to treatment, and use the information to obtain and adjust treatment accordingly.
- Co-locate medical nurse practitioners/primary care physicians in behavioral health facilities – provide routine primary care services in the behavioral health setting via a nurse practitioner or physician out-stationed from the full-scope health care home.
- Embed nurse care managers within the primary care team working in the behavioral health setting. For people who have established external primary care relationships, the nurse care manager would work to establish this team relationship with outside healthcare providers.

Consistent with the overarching goal and vision of RHP 1, Andrews Center is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of Andrews Center. Northeast Texas is an area where patients face many challenges in accessing primary, specialty, and behavioral health care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, Andrews Center is proposing to provide integrated primary and behavioral health care services to address the identified gaps in the current community behavioral health system. Expanding behavioral health care access with primary and behavioral health integration meets several community needs outlined by RHP 1, including: insufficient access to behavioral care services (CN.2), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

The Andrews Center will work with community partners to develop a program to meet the goals above. Though the details of such a program will be determined in the initial planning year of the DSRIP project, it is envisioned that a program will be developed to improve the integration of behavioral health and primary care services in Region 1. This integration will occur in a "bidirectional" manner.

More specifically:

- The program will integrate primary healthcare by embedding primary care physicians or nurse practitioners into behavioral health care clinics to promote on-site co-management of patients with behavioral health and physical health conditions.
- We will enhance coordination of primary care services for patients with severe mental illness who are established with a primary care doctor in the community utilizing an RN Patient Care Manager who is responsible for coordinating all aspects of the clients care, whether it is from the physician on-site or the client's off-site personal physician.
- Behavioral health providers will be able to support the client in taking charge of his or her health and personal well-being. Additionally, the RN Patient Care Manager will assist patients when appropriate to transition their primary care services to a Primary care practitioner in the community.

Specific project components include the following:

a. The integrated care project will be located in the Andrews Center Behavioral Health facility in Smith County; the current facility has adequate space to add Primary care providers to the already established Behavioral Health providers. This location will require only minimal modifications and equipment to begin the project. This project will require no capital investment. This location will provide convenient access for patients, transportation resources and will be conducive to providers working together.

b. Provider agreements will be developed for scheduling and information sharing purposes.

c. Policies and procedures will be developed that will include Protocols and processes for communication, data-sharing, and referrals between behavioral and physical health providers.

d. Integration of Primary Care into the Behavioral Health setting will require initial recruitment of primary care physicians or nurse practitioners. The Andrews Center currently has three Psychiatrists and two Mental Health Nurse Practitioners on staff at this location who will continue to provide Behavioral Health Care.

e. Training of physical and behavioral health providers in Policies, Procedures and protocols addressing effective communication and team approach will occur with project staff.

f. Data reporting, communication and collection tools to be used in the integrated setting will be developed through the Management Information System at the Andrews Center.

g. Necessary legal agreements needed in a collaborative practice will be developed as needed.

h. The project will be implemented in an established facility with utilities and building services available. No capital investment will be required.

i. Data collection and reporting mechanisms to track the utilization of integrated services and health care outcomes will be developed and implemented utilizing the Andrews Center Management and Information System collection and reporting mechanisms to track the utilization of integrated services and health care outcomes will be developed and implemented.

j. Data collected will be analyzed for Quality improvement purposes to identify project impacts, to identify opportunities to scale all or part of the project to a broader patient population, and key challenges will be identified annually and at the completion of the project improvement methods such as identifying project impacts, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges will be conducted as part of the project.

Starting Point/Baseline: In FY 2012, 1,878 Smith County Andrews Center adults with serious mental illness were served and 64% (1202) have no primary care physician. Given the low economic status of this population, these individuals face many barriers to finding primary health care, which include: No insurance, Inability to pay for out of pocket health expenses, Unpaid medical bills from past experiences, Lack of transportation, Lack of understanding of the process of seeking free or reduced price health care, and long drives for those who live in rural areas. Additionally there currently exists no coordinated efforts for collaboration with behavioral health or primary health providers and referral for specialty care is not currently initiated by the Behavior health service staff. The Andrews Center has attempted several collaborative relationships over the past five years with local primary care providers to integrate behavior health into a primary health setting. Efforts have been unsuccessful due to a variety of problems, ranging from instability of the healthcare provider agency, lack of professional resources, patients not comfortable with receiving services in an unfamiliar location and primarily lack of funding for such a project.

As summarized in the table below, we have predicted Andrews Center's estimated demand for integrated health programs.

Estimated Primary Care Demand Andrews Center-Smith County	
Adult BH Population in Smith County	1878
% Patients w/o Primary Care Phys	64%
Primary Care Patient Demand	1202
Predicted PC Visits Per Year	3
Primary Care Visit Demand	3606
Target % Served	30%
Target Visits Served	1082

Reflects DY5 Predicted Volume

Rationale: In this new initiative to integrate care delivery, patients with concomitant mental health and primary care needs will receive care in a more integrated model, resulting in improved patient outcomes and experiences. In addition, this integration will also enhance the work life of providers and staff at both Andrews Center Behavioral Health clinics and primary care clinics by facilitating their ability to obtain needed services for their patients in a more coordinated and accessible manner. As noted in the Region 1 community needs assessment (CN.2 and CN.5), there is a shortage of behavioral health providers and services causing inappropriate ED utilization. Our integration plan will strive to fill the shortage gap of behavioral health services—approximately 45% of all behavioral health patients do not have a primary care provider.

One of the key issues to emerge nationally in discussions of primary care transformation is how to effectively integrate behavioral health services and Physical Health Services. Conditions such as anxiety, depression, and substance use are prevalent among patients cared for in the Behavioral Health setting, and these conditions often co-exist with chronic medical conditions including diabetes, hypertension and obesity. Primary Physical Health Care for individuals in the behavioral Health setting is far from optimal, and many barriers exist in coordinating behavioral health services and primary care. These challenges are especially prominent for patients with serious mental illness who have disproportionate rates of chronic medical illness and early mortality. The need for linkage between behavioral health and primary care is evident on several fronts:

1) People with chronic medical illnesses are more likely to experience mental illness;
2) Individuals with severe mental illness have higher rates of hypertension, cardiovascular disease, HIV/AIDS, metabolic syndrome, obesity, and diabetes;
3) Co-morbidity of mental health issues and chronic illness is associated with poor medication adherence, inability to follow treatment regimens and increased use of emergency rooms;
4) Anti-psychotic medications have been linked with side effects such as obesity, high blood glucose levels, and diabetes; and
5) People who have mental illnesses are more likely to have sedentary lifestyles and/or abuse alcohol, cigarettes, and/or drugs, leading to exacerbated health conditions.
6) Other factors that put people with serious mental illness at higher risk for health problems include unsafe sexual behavior, residence in homeless shelters and group

care facilities (increased exposure to TB as well as inability to modify diet), and higher rates of victimization and trauma, incarceration, and social isolation.

Analysis of Andrews Center service use data suggests a mismatch in both directions. Many patients receiving care at Andrews Center mental health clinics do not have a primary care medical home. At the same time, many patients with behavioral health conditions using primary care medical homes again who has these to start do not receive co-management from a behavioral health professional.

Related Category 3 Outcome Measures: The primary and behavioral health integration project will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients (IT-9.2). Giving behavioral health patients access to primary care—and vice versa—will decrease the need for services in the ED. The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in ED visit reduction. Andrews Center plans to decrease ED visits for patients receiving interventions through primary and behavioral care integration by 10% and 15% in demonstration years 4 and 5, respectively.

The previously stated project description and rationale further describes how implementing the primary/behavioral integration program will reduce emergency department visits for behavioral health/substance abuse patients.

Relationship to Other Projects: All three of Andrew Center's project plans work together to expand behavioral health services and to prevent potential admissions, readmissions, and ED visits. The first step is to intervene at the ED and appropriately send behavioral health patients to a Regional Crisis Response Centers. These crisis intervention and stabilization centers (138365512.1.1) will more efficiently serve behavioral health needs and get them specialized, cost effective care. Another intervention point is the criminal justice system through our jail diversion program (138365512.2.1). Similar to the crisis stabilization program, our community health workers and criminal justice system stakeholders will work together to keep behavioral health patients out of jail. After crisis stabilization and jail diversion, patients will be guided to the appropriate follow up care in our proposed physical-behavioral health integration program (138365512.2.2). Patients will have access to our psychiatrists and primary care physicians, in order to meet their physical and behavioral health needs. In order to maintain the appropriate follow-up care, Andrews Center has a need to expand outpatient therapy services with 2 new licensed therapists (138365512.2.3).

Relationship to Other Performing Providers' Projects in the RHP: Andrews Center has ensured that all project plans fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of similar projects by Access and Community Healthcore in the RHP. Furthermore, we

will participate in learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: Andrews Center plans to participate in RHP-wide learning collaboratives with other providers with similar primary/behavioral care integration projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: Studies have demonstrated the adverse effects of emergency department boarding of behavioral health patients—often the result of lacking appropriate primary and behavioral care. Excessive resource utilization, throughput, and financial impact of psychiatric patients awaiting inpatient placement places a burden on hospital EDs and negatively impacts appropriate care for the behavioral health population. The financial impact of psychiatric boarding accounts for a direct loss of $1,198 compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding costs the department $2,264 per patient. Lastly, psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers (additional patients) per psychiatric patient—decreasing financial revenue for the ED and costing the healthcare system more reimbursement dollars. In addition to excessive ED cost, patients also incur costs for being admitted to an inpatient facility and/or jail. These costs, along with Sheriff's Deputy oversight in the ED, often build on the initial ED cost since the ED is the typical initial access point.

The following table shows the potential ED and inpatient savings of primary and behavioral health care integration. These savings exceed the cost the implementation and the overall DSRIP funding. The cost savings for the community and cost of implementation are shown below:

Estimated Annual Savings Primary/Behavioral Health Integration	
1082 Pts Served @ 15% Reduction of Services	270
ED Cost per Psychiatric Patient[1]	$2,264
ED Savings	**$611,959**
Psychiatric Inp Admit from ED @ 35.1%[1]	95
Inpatient Psychiatric ALOS	10
Cost per Inpatient Psychiatric Day[2]	$685
Inpatient Psych Savings	**$649,175**
Psych ED Patients Jailed @ 5%	14
Days in Jail per Offender[3]	260
Cost of Psychiatric Inmate per Day[3]	$137
Jail Savings	**$481,404**
Sheriff's Deputies per 270 Patients	1.1
Sheriff's Deputies per Year	$53,500
Deputy Savings	**$58,850**
Total Estimated Savings	**$1,801,388**

4) Emergency Medicine International, 2012
5) CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011
6) National Alliance on Mental Illness

Note: Reflects DY5 Predicted Volume of Service

***138365512*.2.2**	***2.15.1***	***2.15.1.A-J***	**Integrate Primary and Behavioral Health Care Services**
Andrews Center			***138365512***
Related Category 3 Outcome Measure(s):	***138365512*.3.3**	*3.IT-9.2*	*ED Appropriate Utilization*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.15.1.P-3 Milestone: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. **Metric: 2.15.1.P-3.3** Number of referrals which follow the established standards **Baseline/Goal:** None **Data Source**: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results **Milestone 1 Estimated Incentive Payment:** $ 1,182,522	**Milestone 2: 2.15.1.I-8** Further integrated services per metrics below: **Metric 1: I-8.1** X% of Individuals receiving both physical and behavioral health care at the established locations. Numerator: Number of individuals receiving both physical and behavioral health care in project sites Denominator: Number of individuals receiving services in project sites. **Baseline/Goal:** 5% (94) of 1,878 Smith County patients receiving physical and behavioral care as of Mar 31, 2014. **Data Source:** Project data; claims and encounter data; medical records **Metric 2: I-8.1** X% of Individuals receiving both physical and behavioral health care at the established locations. Numerator: Number of individuals receiving both physical and behavioral health care in project sites Denominator: Number of individuals receiving services in project sites. **Baseline/Goal:** 10% (188) of 1,878 Smith County patients receiving physical and behavioral care as of Sept 30, 2014. **Data Source:** Project data; claims and encounter data; medical records **Milestone 2 Estimated Incentive Payment:** $ 1,298,628	**Milestone 3: 2.15.1.I-8** Further integrated services per metrics below: **Metric 1: I-8.1** X% of Individuals receiving both physical and behavioral health care at the established locations. Numerator: Number of individuals receiving both physical and behavioral health care in project sites Denominator: Number of individuals receiving services in project sites. **Baseline/Goal:** 15% (282) of 1,878 Smith County patients receiving physical and behavioral care as of Mar 31, 2015. **Data Source:** Project data; claims and encounter data; medical records **Metric 2: I-8.1** X% of Individuals receiving both physical and behavioral health care at the established locations. Numerator: Number of individuals receiving both physical and behavioral health care in project sites Denominator: Number of individuals receiving services in project sites. **Baseline/Goal:** 20% (376) of 1,878 Smith County patients receiving physical and behavioral care as of Sept 30, 2015. **Data Source:** Project data; claims and encounter data; medical records **Milestone 3 Estimated Incentive Payment:** $ 1,389,201	**Milestone 4: 2.1.I-8** Further integrated services per metrics below: **Metric 1: I-8.1** X% of Individuals receiving both physical and behavioral health care at the established locations. Numerator: Number of individuals receiving both physical and behavioral health care in project sites Denominator: Number of individuals receiving services in project sites. **Baseline/Goal:** 25% (470) of 1,878 Smith County patients receiving physical and behavioral care as of Mar 31, 2016. **Data Source:** Project data; claims and encounter data; medical records **Metric 2: I-8.1** X% of Individuals receiving both physical and behavioral health care at the established locations. Numerator: Number of individuals receiving both physical and behavioral health care in project sites Denominator: Number of individuals receiving services in project sites. **Baseline/Goal:** 30% (563) of 1,878 Smith County patients receiving physical and behavioral care as of Sept 30, 2016. **Data Source:** Project data; claims and encounter data; medical records **Milestone 4 Estimated Incentive Payment:** $ 1,342,228
Year 2 Estimated Total	Year 3 Estimated Total DSRIP Funding:	Year 4 Estimated Total DSRIP Funding:	Year 5 Estimated Total DSRIP Funding:

DSRIP Funding: $1,182,522	$1,298,628	$1,389,201	$1,342,228
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$5,212,579***			

Project Option: 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals needing outpatient therapy
Unique Project ID Number: 138365512.2.3
Performing Provider Name/TPI: Andrews Center 138365512

Project Abstract

Provider Description: Andrews Center Behavioral Healthcare System is a non-profit, comprehensive mental health and mental retardation center. Services are provided in a five-county area of East Texas (Smith, Wood, Rains, Van Zandt and Henderson) with an estimated population of 390,014.

Intervention: This project will increase therapy services in Smith, Henderson, Van Zandt, Wood, and Rains counties by expanding an intensive therapy program for the behavioral health population. The addition of 2 licensed therapists will allow for therapy appointments for an underserved population of individuals with mental health/substance use issues.

Need for the Project: The community needs assessment for RHP 1 cites insufficient access to behavioral care services (CN.2). Therapy services have been demonstrated to improve the overall functioning of individuals with Mental illness; through the use of Therapeutic modalities that are evidence based practices such as Cognitive Behavioral Therapy, Cognitive Processing Therapy, and recognized curricula by the State of Texas. It is anticipated that as a result of increased therapy services individuals served will show a decrease in emergency room visits and hospital bed days.

Target Population: The target population is behavioral health patients in need of outpatient therapy. Many of the patients targeted for outpatient therapy services have been on a waiting list due to limited resources and currently have no access to these services. It is anticipated that with the expansion of therapy services approximately 200 patients per year will be served with a Medicaid and indigent population of at least 55%.

Category 1 or 2 Expected Patient Benefits: The expansion of outpatient therapy services seeks to serve 200 patients per year. We will gather data to confirm our estimated baseline of 50% (100 individuals) that will show improvement in GAF (Global Assessment of Functioning) scores in DY 3 and will adjust appropriately going forward. Our performance goal is a 5% increase over baseline in the number of individuals who show improved scores on the GAF in DY4, and a 10% increase in individuals with improved scores in DY5. These percentages equate to a total of 105 and 110 individuals showing improvement in DY4 and DY5 respectively. Patients will benefit from much improved access to therapy services and shorter waits for appointments. We anticipate a minimum of 55% of these patients will be from the Medicaid/indigent population.

Category 3 Outcomes: Expanded outpatient therapy services will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients (IT-9.2). Andrews Center plans to decrease ED visits for patients receiving

interventions through expanded outpatient therapy services by 10% and 15% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: The Andrews Center will seek to increase therapy services in Smith, Henderson, Van Zandt Wood, and Rains counties by expanding an intensive therapy program for the behavioral health/substance use population. Increasing therapy capacity will require the recruitment of 2 licensed therapists (Professional Counselors or Clinical Social Workers) and .5 support staff. This added staff will enable the expanded services described below. Specifically, we will validate our estimated baseline improvement as measured on standardized instruments, of 50% (100 individuals) in DY3. We anticipate showing clear improvements of 5% (105 individuals) over baseline in DY4 and 10% (110 individuals) over baseline in DY5 as measured on standardized instruments such the GAF (Global Assessment of Functioning).

A high number of clients served by the Andrews Center have co-occurring disorders in mental health and substance use, which often contributes to a high rate of hospital admissions and crisis contact. For FY 2012 the Andrews Center served 6277 adults with mental health issues, of those served 63% are uninsured, many are unemployed, and lack sufficient housing. The additional therapists provided in this project will increase access to services and increase the level of functioning to clients that fall into these categories.

Consistent with the overarching goal and vision of RHP 1, Andrews Center is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of Andrews Center. Northeast Texas is an area where patients face many challenges in accessing primary, specialty, and behavioral health care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes. Additional access to therapy services will substantially increase the overall behavioral health status of the Andrews Center catchment area.

In order to meet the healthcare needs of our population within Northeast Texas, Andrews Center is proposing to expand outpatient therapy capacity in order to decrease the need for more costly future inpatient services, and the inappropriate usage of our local emergency departments. Expanding behavioral health care access with outpatient therapy services meets several community needs outlined by RHP 1, including: insufficient access to behavioral care services (CN.2), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

The project plan is to expand therapy capacity by increasing the workforce with qualified licensed staff including Licensed Professional Counselors (LPC) and/or Licensed Clinical Social Workers (LCSW). Therapeutic modalities will be evidence based practices such as Cognitive Behavioral Therapy, Cognitive Processing Therapy, and recognized curricula by the State of Texas. The therapy will be provided in group and/or individual sessions within a professional setting. The comprehensive strategic therapy plan will encompass elements designed to engage clients in therapeutic services to ensure maximum utilization of this service. Each

therapist will be required to maintain 50% direct service time to meet the improvement metrics.

Specific project components include the following:

a. In assessing the needs of clients served by the Andrews center it was determined that 233 people remain on the waiting list for therapy services and have been unable to access services due to lack of resources. These individuals have a mental health diagnosis of Major Depression, Schizophrenia, Bi Polar Disorder, and other major mental illnesses.

b. A review of the current literature on CBT or Cognitive Behavioral Therapy was undertaken. The goals of Cognitive Behavioral Therapy are to correct cognitive distortions, reduce emotional stress, and to cope with problems actively. There is evidence to support that CBT has been successful in the treatment of anxiety disorders, depression, eating disorders, low back pain, personality disorders, psychosis, schizophrenia, substance use disorders, fibromyalgia, spinal-cord injuries etc. Evidence states that CBT is superior in the long run to the use of benzodiazepines and insomnia medications. In a review of 150 research studies 87% of individuals with Panic Disorder improved with only a 10% relapse rate. The University of Michigan Depression Center found CBT achieved "significant improvements "in more than 75% of patients.

c. Individuals who receive therapy services will be assessed using standardized instruments, such the GAF, (Global Assessment of Functioning) initially and at the completion of their course of therapy to determine if they have shown a decrease, increase or stabilization in their functioning level.

d. Andrews Center services will offer community-based specialized interventions based on individual needs for behavioral health patients needing outpatient therapy, including: Specialized behavioral therapies, psychiatric services, case management and mental health rehabilitation training.

e. Throughout the course of the project outcomes will be assessed to determine the impact of interventions based on results of a standardized instrument, such as the GAF for those receiving therapy as well as correlation of improvement on the GAF and mental health diagnosis. It is anticipated that individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments will be at a baseline of 50% (100 individuals) in DY3, and improve over this baseline by 5%, (105 individuals) in DY 4 and 10% (110 individuals) in DY5.

Starting Point/Baseline: The licensed therapists in this project will be well-trained in CBT Cognitive Based Therapy and CPT Cognitive Processing Therapy, and be required to maintain the needed CEU's in their counseling area. The project will seek professionals who have experience in working with individuals with mental health, substance use disorders, developmental disabilities, and the forensic population. There are currently 233 individuals who are on a waiting list for counseling services who could benefit from counseling but due to lack of resources have been underserved or not receiving any services. The Andrews Center screens an average of 247 people per month with approximately 83% determined eligible for

services, as the population grows the demand for Behavioral Health services including Therapy services increases. Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in ED visit reduction. Andrews Center plans to decrease ED visits for patients receiving interventions through expanded outpatient therapy services by 10% and 15% in demonstration years 4 and 5, respectively.

Rationale: Evidence based therapies will be utilized to assist clients in the community to improve stabilization. Therapy is a behavioral health intervention that is proven to provide education about one's diagnosis, to learn coping skills and techniques to manage issues related to the diagnosis. Therapy has been shown to be effective in helping individuals with behavior health issues to over time maintain a level of functioning in the community that allows them independence on an outpatient basis rather than inpatient basis. The end result will be improved overall global functioning and a decrease in symptoms.

Research indicates that evidence based therapies are effective tools in preventing psychiatric hospital admissions and re-admissions. The goal of providing increased access to additional therapy will impact the lives of persons with disabilities in a positive way. It would provide the emotional support and coping skills needed to decrease admissions to the hospital, and reduce emergency department visits. It would improve stabilization and assist in maintaining a high level of functioning on an outpatient basis. Increased access for services will allow more clients to receive assistance. Additionally, the addition of therapist will allow the Andrews Center to relieve lengthy waiting list for therapy services, enabling the Center to meet community needs.

Related Category 3 Outcome Measures: According to the Texas Department of State Health Services, nearly 50% of 2008 hospitalizations in Texas had a secondary diagnosis of a mental health condition. A vast majority of these hospitalizations initiated in the ED due to the shortage of behavioral health services.

Expanded outpatient therapy services will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients (138365512.3.4). The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in ED visit reduction. Andrews Center plans to decrease ED visits for patients receiving interventions through expanded outpatient therapy services by 10% and 15% in demonstration years 4 and 5, respectively.

The previously stated project description and rationale further describes how expanding behavioral health outpatient therapy services will reduce emergency department visits for behavioral health/substance abuse patients.

Relationship to Other Projects: All four of Andrew Center's project plans work together to expand behavioral health services and to prevent potential admissions, readmissions, and ED visits. The first step is to intervene at the ED and appropriately send behavioral health patients to a Regional Crisis Response Centers. These crisis intervention and stabilization centers (138365512.1.1) will more efficiently serve behavioral health needs and get them specialized, cost effective care. Another intervention point is the criminal justice system through our jail diversion program (138365512.2.1). Similar to the crisis stabilization program, our community health workers and criminal justice system stakeholders will work together to keep behavioral health patients out of jail. After crisis stabilization and jail diversion, patients will be guided to the appropriate follow up care in our proposed physical-behavioral health integration program (138365512.2.2). Patients will have access to our psychiatrists and primary care physicians, in order to meet their physical and behavioral health needs. In order to maintain the appropriate follow-up care, Andrews Center has a need to expand outpatient therapy services with 2 new licensed therapists (138365512.2.3).

Relationship to Other Performing Providers' Projects in the RHP: Andrews Center has ensured that all project plans meet the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of similar projects by Access and Community Healthcore in the RHP. Furthermore, we will participate in learning collaboratives to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: Andrews Center plans to participate in RHP-wide learning collaboratives with other providers. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: The Andrews Center cost per inpatient psychiatric bed per day can exceed $850, compared to one therapy session at $120. At a minimum of 10 sessions per client, we project that 2 additional therapists will be able to provide 2,250 sessions for 200 clients. Providing therapy for 200 clients rather than inpatient utilization will save approximately $1.4 million per year in future institutionalization costs.

Estimated Annual Savings Andrews Center Therapy Capacity Expansion			
New Population Served			200
Sessions Per Year	@ 10 per patient		2000
Therapy Cost Per Session		$	120
Therapy Cost Per Year		$	240,000
New Population Served			200
Inpatient Bed Utilization Per Year	ALOS @ 10 days		10
Inpatient Cost Per Day		$	850
Inpatient Bed Cost Per Year		$	1,700,000
Estimated Annual Savings:	$		1,460,000

138365512.2.3	***2.13.1***	***2.13.1.A-E***	**Interventions tailored towards individuals needing outpatient therapy**
Andrews Center			***138365512***
Related Category 3 Outcome Measure(s):	***138365512.3.4***	*3.IT-9.2*	*ED Appropriate Utilization*
Year 2	Year 3	Year 4	Year 5
Milestone 1: P-2 Design community-based specialized interventions for behavioral health patients needing outpatient therapy, including: • Specialized behavioral therapies • Prescription medications **Metric: P-2.1** Project plans which are based on evidence / experience and which address the project goals **Baseline/Goal:** Project Documentation **Data Source**: Project plans and documentation	**Milestone 2: I-5** Functional Status **Metric: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** Determine actual baseline percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments versus estimated 50% (100 individuals) **Data Source:** Standardized functional assessment instruments (e.g. GAF, ANSA, CANS, etc.)	**Milestone 3: I-5** Additional improvement in Functional Status per below: **Metric 1: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF,ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 2.5% (103 individuals) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Mar 31, 2015. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments **Metric 2: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 5% (105 individuals) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Sept 30, 2015. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments	**Milestone 4: I-5** Additional improvement in Functional Status per below: **Metric 1: 2.13.1.I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 7.5% (108 individuals) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Mar 31, 2016. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments **Metric 2: I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (GAF, ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 10% (110 individuals) increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments as of Sept 30, 2016. (new #-baseline) / baseline **Data Source:** Standardized functional assessment instruments

Milestone 1 Est Incentive Payment: $213,113	**Milestone 2 Estimated Incentive Payment:** $239,399	**Milestone 3 Estimated Incentive Payment:** $ 260,913	**Milestone 4 Estimated Incentive Payment:** $ 253,897
Year 2 Estimated Total DSRIP Funding: $213,113	Year 3 Estimated Total DSRIP Funding: $239,399	Year 4 Estimated Total DSRIP Funding: $260,913	Year 5 Estimated Total DSRIP Funding: $253,897
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$967,322***			

Project Option: 2.5.3 – Cost Savings: Implement an innovative, evidence based intervention that will lead to cost savings for providers.
Unique Project ID Number: 138913209.2.1 (Pass 1)
Performing Provider Name/TPI: Titus Regional Medical Center (TRMC) 138913209

Project Abstract

Provider Description:
Titus Regional Medical Center ("TRMC") is a **174** bed hospital in Mount Pleasant, Texas serving the Northeast Texas area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level III Lead trauma center. Mount Pleasant is the county seat of Titus County which has a population of 32,334 per the 2010 Census data and covers 406 square miles. The total service area population of TRMC covers fifteen counties with a total service area population of approximately 220,874.

Interventions:
This project will focus on the implementation of a cost accounting system to provide reasonable, consistent and accepted costing of services in order to measure cost improvement or containment for the services provided by TRMC. The project will implement processes and systems needed to identify, analyze and lower the cost of care to patients, employers, and the government while maintaining high quality outcomes.

Need for the Project:
TRMC does not have an automated cost accounting system and relies on cost to charge ratios for analysis and decision making. The rate of healthcare spending in the United States is unsustainable. To be more flexible and able to react to change in the delivery system, a clear and concise understanding of the cost systems is essential.

Target Population:
The implementation of a cost accounting system lays the foundation for the use of data-based cost and quality measures to identify opportunities for cost efficiencies which touch every patient and payer both as an inpatient and outpatient. The target population is residents of TRMC's fifteen county service area in Northeast Texas that uses the hospital services through the reduction of cost of care and cost containment. The residents of our service area include a Medicaid eligible share of 21% and uninsured/indigent share of 27%.

Category 2 Expended Patient Benefits:
The project seeks to implement a cost accounting system and demonstrate reduction of the cost of care for a chosen diagnosis.

Category 3 Outcomes:
Our goal is to reduce the per episode cost of care related to congestive heart failure based on the cost accounting system's baseline data by the end of the waiver.

Project Narrative

Project Description:

TRMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. Northeast Texas is an area where patients face many challenges in accessing primary and specialty care, preventive care, and chronic disease management. Titus County has a population of 32,334 per the 2010 Census data with 48.2% Caucasian, 40.6 Hispanic and 10.1% African American. The average median household income for Titus County is $39,423. In Titus County as elsewhere, low income, uninsured and minority populations are disproportionately medically disenfranchised.

Titus County has about 30% of children identified as living at or below the poverty level compared to 26% for the state average and 13% for the national benchmark. The uninsured in Titus County is 30% compared to the state average of 26% and the national benchmark of 11%. Unemployment for Titus County is 7.8% compared to state average of 8.2% and the national benchmark of 5.4%.

TRMC provides medical care for a community with a high percentage of minorities, low income, and uninsured who have been challenged by the economic pressures limiting their resources available, yet the need for access to care continues to grow. The only way for public health systems to satisfy these demands is to continue to become more efficient and effective at managing care for the populations we serve.

The goal of this project is to develop a Business Intelligence system with the capability to test methodologies for measuring cost containment, intervention and innovation impacts so they may be applied to other projects or efforts giving Titus Regional Medical Center the ability to measure the efficiency of these initiatives and expand the ability to generate data reports to prioritize our decisions for improvement initiatives. This requires investing in a system which allows us to measure and monitor the impacts of our initiatives on the cost of healthcare.

Five-Year Outcomes:

The five- year expected outcome for this project is to implement a cost accounting system that lays the foundation for the use of data-based cost and quality measures to identify opportunities for cost efficiencies. The outcomes will show cost savings/lowering the cost for care.

Relation to Regional Goals:

This project will complement the regional goal identified in the Community Needs Assessment: "CN.6 Efficiency in and effectiveness of health care delivery." Other health systems will be interested in the outcome of this project and may want to replicate them.

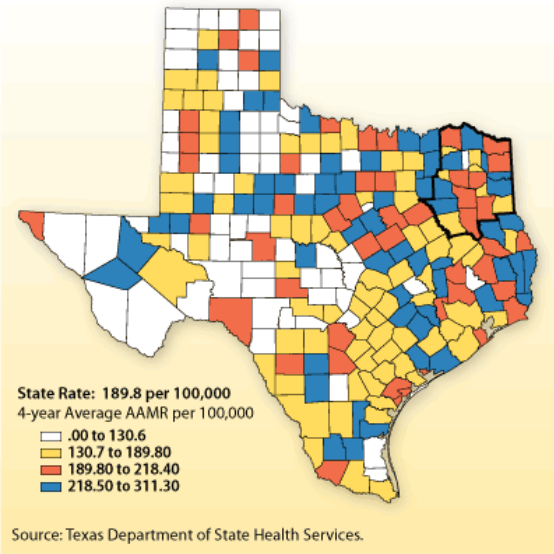
Starting Point/Baseline:
The starting point/baseline for the redesign of cost containment will be the implementation date of the Medicaid Waiver project: December 11, 2011. This project is implementing a new cost based analysis system. Therefore, there is no current baseline. The baseline will be established as one of the process improvements in DY 3.

Documentation of the current systems and the selection of the new cost based analysis system will be provided.

Rationale:
TRMC does not have an automated cost accounting system. Limited resources and growing patient demand have focused resources away from administrative areas to support clinical functions. TRMC relies on basic cost to charge ratios that may work at a global (departmental) level but can provide very inaccurate or inconsistent results at a specific service or provider level due to variations in individual cost to charge comparisons. Finance and analytic staff have addressed the real costs versus what can be pulled from our decision support system for each analysis, creating inefficiencies and long turn-around times.

An accurate cost-accounting methodology is a necessary tool to gauge the impact of quality and efficiency improvement interventions on the cost per unit of service for the delivery of care. Interventions require the investment of numerous resources at many levels of the delivery system. A cost-accounting system provides the system with the necessary tool to gauge the financial return on investment of interventions.

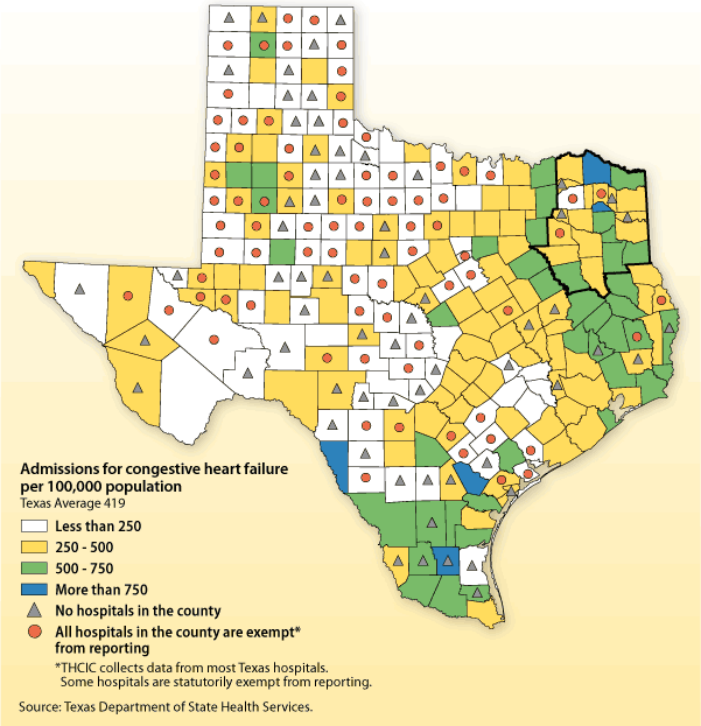
TRMC has selected the cost of care related to congestive heart failure for Category 3 outcomes. Cardiovascular disease is actually a set of heart and blood vessel diseases such as ischemic heart disease (narrowed or blocked blood vessels leading to the heart), stroke and congestive heart failure. These ailments account for two out of every five deaths in Texas. Heart disease and stroke are of particular concern in Upper East Texas, where mortality rates from heart disease are among the highest in the state as evidenced in the below chart.[1]



The Texas Department of State Health Services estimates that the Health Services Region 4, which is the same as the Comptroller's Upper East Texas region, has a 13.5 percent rate of cardiovascular disease, or more than an estimated 108,000 persons. Across the state, the estimated prevalence of cardiovascular disease is 8.5 percent, or more than 1.4 million persons affected. The TRMC service area is included in this Upper East Texas region.

Costs to the region's hospitals due to heart disease totaled $436.5 million in 2005, while hospital costs due to congestive heart failure reached $142.8 million. Stroke accounted for another $112.1 million in hospital costs. Note that these numbers do not include other medical costs, including medicine, doctor visits and therapy, which are associated with treating cardiovascular disease.[2]

Texas hospital inpatient discharge data indicate that counties in the Upper East Texas region have a higher-than-average number of admissions for congestive heart failure per 100,000 residents as noted below.



Community Needs:
All required components of this project will be addressed by this endeavor and are needed in this region. The need being addressed by this project is "CN.6 – Efficiency in and effectiveness of health care delivery."

Related Category 3 Outcome Measures:
The overall objective of Category 3 is to assess the effectiveness of expanding primary care access for Titus County. TRMC has selected one domain to measure for our Category 2 project:

OD – 5 Cost of Care

IT – 5.2 Per episode cost of care

Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. TRMC will choose a diagnosis in DY 4 to track as the measurement of reduction in cost of care.

Improvement in Cost of Care will benefit our community directly through lower costs to perform services and additional monies available to invest into our facility.

Relationship to Other Projects and Measures:
All of the projects of TRMC complement each other to meet the transformational goals and the three aims of CMS. Expansion of primary care access, improved access to specialty care, reduction in expenses through cost containment and the implementation of a Rapid Medical Exam in the ED are consistent with each other and complement the goals of each project.

Relationship to Other Performing Projects in the RHP1:
Only one other performing provider is including redesign of cost containment in their projects. This further raises the importance of this project for the other performing providers for us to serve as a learning tool for them on best practices and elements of implementation analysis. It is our full intention to participate in and lead some of the learning collaborative opportunities to share best practices.

Plan for Learning Collaboratives:
Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. TRMC believes in and supports the value of learning collaborative and plans to support the plans of Region 1. The system pledges to develop, support, participate, and lead the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to have our collaboratives inform others of our experiences and best practices acquired and learn from others in the state. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, TRMC, and Mother Frances Hospital, have met to discuss the project planning process and selection of projects.

Project Valuation:
The value of this project is based on the fact that it will allow TRMC to accurately measure the costs of its health care services. As a result, TRMC will be able to better manage and improve the efficiency and cost effectiveness of its health care services. This will directly impact the community need to increase the efficiency and effective of health care services. This project and its positive results are designed to be inherently sustainable. Implementation of cost accounting will provide the ability to continue measuring the efficiency and cost effectiveness of care. TRMC will continue to measure its cost effectiveness and make improvements into the future. By tracing trends over time and against national best practice benchmarks, this project will allow for meaningful improvements in care patterns, evidence based medicine, and business practices. Improvements become possible across the continuum of care in multiple disciplines. The resulting cost savings will create savings to the health care system and low income patients in NE Texas. Decreasing the cost of health care will drive secondary impacts to the region such as increased use of preventive health care services and use of health care services in an appropriate environment.

The implementation of a cost accounting system will require the purchase of a cost accounting software and required hardware components estimated at approximately $750,000. In addition, the installation of the system and process will require considerable amount of hospital financial staff time to develop the processes and data which will be used in the cost accounting process.

TRMC recorded $65.8 million in operating expenses in fiscal 2012. Salaries and agency costs were $27.5 million or 42% of the total operating expenses. Supplies resulted in $9.7 million or

15% of these expenses. Every 1% decrease in total expenses results in savings to the community of $658,000.

The financial impact and costs above are greater than TRMC's average DSRIP funding request for this project of approximately $721,400 per year (including Category 2 and 3) so that the Medicare program accrues a net benefit.

[1] Texas Department of State Health Services, *Texas Plan to Reduce Cardiovascular Disease and Stroke* (Austin, Texas, May 2005), pp. 38-40, http://www.dshs.state.tx.us/wellness/PDF/update05.pdf. (Last visited September 24, 2008.)

[2] Texas Department of State Health Services, "Cardiovascular Health Facts 2001-2005: Texas Health Services Region 4," http://www.dshs.state.tx.us/wellness/PDF/FactSheetRg408.pdf. (Last visited September 24, 2008.), and Texas Department of State Health Services, "Texas Cardiovascular Health Facts 2001-2005," http://www.dshs.state.tx.us/wellness/PDF/Fact%20SheetTexas08.pdf. (Last visited September 24, 2008.)

138913209.2.1	*2.5.3*	*2.5.3*	**2.5 – *REDESIGN FOR COST CONTAINMENT***	
Titus Regional Medical Center				138913209
Related Category 3 Outcome Measure:	*138913209.3.3*	***IT-5.2***	Per episode cost of care	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-3: Implement the cost-accounting methodology and related systems to measure intervention impacts. Metric 1 [*P-3.1*]: Documentation of adoption and installation of cost accounting system. Baseline: 0 – TRMC does not have a cost accounting system as of 9/30/12. Goal: Document the adoption and installation of cost accounting system. Data Source: Cost Accounting Implementation Project Timeline and presentation to CEO of installation of cost accounting system. **Milestone 1 Estimated Incentive Payment (*maximum amount)*: $564,297**		**Milestone 2 P-1**: Develop/indentify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions. Metric 1 [P-1.1]: Cost accounting methodology per metric. Baseline: TRMC does not have a cost accounting system as of 9/30/12. Goal: Documentation of the methodology and metric . Data Source: Cost-accounting system or another administrative, financial or clinical data set. **Milestone 2 Estimated Incentive Payment: $288,570.50** **Milestone 3 P-5**: Train Finance staff on costing methodologies and define, develop, and document methodologies with departments for allocation of costs to specific services. Metric 1 [P-5.1]: Staff trainings and department	**Milestone 4 P-2**: Establish a baseline for cost. Metric 1 [P-2.1]: Submission of baseline data. Baseline: Establish a baseline for cost using DY 3 data. Goal: Submission of baseline data. Data Source: Cost-accounting system or another administrative, financial or clinical data set. **Milestone 4 Estimated Incentive Payment: $288,123** **Milestone 5 I-10**: Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Metric 1 [I-10.1]: Measure improvement per episode cost of care related to chosen diagnosis. Numerator: Total costs related to care of chosen specific diagnosis.	**Milestone 6 I-10**: Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Metric 1 [I-10.1]: Measure improvement per episode cost of care related to chosen diagnosis. Numerator: Total costs related to care of chosen specific diagnosis. Denominator: total patients within a chosen specific diagnosis. Baseline: Baseline data collected above from DY 3. Goal: Improve cost against baseline. Data Source: Cost Accounting System **Milestone 6 Estimated Incentive Payment: $465,292**

138913209.2.1	***2.5.3***	***2.5.3***	**2.5 – *REDESIGN FOR COST CONTAINMENT***	
Titus Regional Medical Center				138913209
Related Category 3 Outcome Measure:	*138913209.3.3*	***IT-5.2***	Per episode cost of care	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	specific methodologies. Goal: Submission of trainings and department documents. Data Source: Documentation of training materials and human resource records. **Milestone 3 Estimated Incentive Payment: $288,570.50**		Denominator: total patients within a chosen specific diagnosis. Baseline: Baseline data collected above from DY 3. Goal: Improve cost against baseline. Data Source: Cost Accounting System **Milestone 5 Estimated Incentive Payment: $288,123**	
Year 2 Estimated Milestone Bundle Amount: $564,297	**Year 3 Estimated Milestone Bundle Amount: $577,141**		**Year 4 Estimated Milestone Bundle Amount: $576,246**	**Year 5 Estimated Milestone Bundle Amount: $465,292**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $2,182,976				

Project Option: 2.8.1 – Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Unique Project ID Number: 138913209.2.2 (Pass 1)
Performing Provider Name/TPI: Titus Regional Medical Center (TRMC) 138913209

Project Abstract

Provider Description:
Titus Regional Medical Center ("TRMC") is a **174** bed hospital in Mount Pleasant, Texas serving the Northeast Texas area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level III Lead trauma center. Mount Pleasant is the county seat of Titus County which has a population of 32,334 per the 2010 Census data and covers 406 square miles. The total service area population of TRMC covers fifteen counties with a total service area population of approximately 220,874.

Interventions:
This project will focus on increasing the number of patients seen in a more appropriate level of care through the implementation of a Rapid Medical Evaluation ("RME") system for the ED patient flow.

Need for the Project:
Based on the accessibility of primary care in our area and economic demographics, the Emergency Room is used as an alternative to primary physician care after normal business hours and on weekends creating an inefficient and high cost of service.

Target Population:
The target population is residents of TRMC's fifteen county service area in Northeast Texas that uses the emergency room services. The residents of our service area include a Medicaid eligible share of 21% and uninsured/indigent share of 27%.

Category 2 Expended Patient Benefits:
The project will decrease patient time to provider, decrease patient turn-around time for discharge and decrease the amount of patients who leave without being seen.

Category 3 Outcomes:
Our goal is to increase patient satisfaction scores for ED patients related to timely care, appointments, and information.

Project Narrative

Project Description:
TRMC is located in Northeast Texas in Mount Pleasant. Titus County has a population of 32,334 per the 2010 Census data with 48.2% Caucasian, 40.6 Hispanic and 10.1% African American. The average median household income for Titus County is $39,423. In Titus County as

elsewhere, low income, uninsured and minority populations are disproportionately medically disenfranchised. These individuals often have multiple chronic conditions. Without regular primary care, chronic conditions are likely to become acute episodes, putting patients at risk for disability and premature death. Extended delays in appointment scheduling, long waiting times and denial by physicians to accept all forms of medical coverage have a significant negative impact on patient satisfaction, provider satisfaction and quality of care discouraging people from using health care proactively. As a result of limited primary care, many patients are cared for exclusively in specialty care clinics and/or emergency rooms; these settings are not designed to provide comprehensive assessment, preventive care and coordination. With process improvements related to flow of patients in the ED, the appropriate level of care can be assigned accordingly.

This project will focus on the implementation of a Rapid Medical Evaluation ("RME") process for the ED patient flow. RME places one or more providers (physician, NP or PA) in triage to perform the initial Medical Screen Exam ("MSE") and order testing on the patient or treat and release the patient without ever taking up a bed in the ED. The net result of the project is:

- Decrease in patient time to provider
- Decrease in patient turn-around time for discharged patients
- Decrease in patients who leave with being seen
- Increase in ED capacity
- Increase in patient satisfaction

Challenges:
An increasing low income population growth has increased the demand for primary care access and wait-time for the next available appointment. Our direct care centers are not available after hours or on the weekends. More providers are necessary to provide for the increasing number of patients. This shortage of primary care providers has resulted in limited options for Medicaid and Medicare patients and extremely limited resources for uninsured patients without a payor source in every community. The uninsured percentage for Titus County is 30% compared to the state average of 26% and national benchmark of 11%. . Preventable hospital stays in Titus County was 94 compared to the state average of 73 and the national benchmark of 49. This population is diverted many times to the Emergency Room as their first option.

The increase in patients seeking care in the Emergency Department that are non-emergent has increased the cost for level of service required. In addition, the patients who need advanced level care in an acute care hospital are forced to wait additional time due to these non-emergent visits.

Regional Goals:
This project will complement the regional goal identified in the Community Needs Assessment: "CN.5 – Inappropriate emergency department utilization." Other health systems will be interested in the outcome of this project and may want to replicate them.

Five-Year Outcomes:

The minimum expected five-year outcome of this project is to decrease the door to provider time, decrease the patient turn around time to discharge and decrease the Left Without Being Seen % (LWBS %).

Starting Point/Baseline:

TRMC's effort to implement the RME is a new process. As for calculations regarding ED statistics, TRMC will use May 1, 2012 through December 31, 2012 as the baseline for these calculations. TRMC implemented a tracking system on May 1st which enabled the hospital to track this level of visit. The baseline by month has been included below:

Level:	**05/31/2012**	**06/30/2012**	**07/31/2012**	**08/31/2012**	**09/30/2012**	**10/31/2012**	**11/30/2012**
Unassigned	58	64	64	74	48	41	31
Level 1 - Unstable (Highest)	7	12	7	7	6	12	19
Level 2 - High Risk	170	125	105	151	152	196	208
Level 3 - Two or Less Resources	1,029	982	1,091	1,080	1,169	1,219	984
Level 4 - One Resource	508	468	433	422	396	344	441
Level 5 - No Resources (Lowest)	135	110	104	103	83	85	86
Total	**1,907**	**1,761**	**1,804**	**1,837**	**1,854**	**1,897**	**1,769**

% Excluding Unassigned:	**05/31/2012**	**06/30/2012**	**07/31/2012**	**08/31/2012**	**09/30/2012**	**10/31/2012**	**11/30/2012**
Level 1 - Unstable (Highest)	0.38%	0.71%	0.40%	0.40%	0.33%	0.65%	1.09%
Level 2 - High Risk	9.19%	7.37%	6.03%	8.56%	8.42%	10.56%	11.97%
Level 3 - Two or Less Resources	55.65%	57.87%	62.70%	61.26%	64.73%	65.68%	56.62%
Level 4 - One Resource	27.47%	27.58%	24.89%	23.94%	21.93%	18.53%	25.37%
Level 5 - No Resources (Lowest)	7.30%	6.48%	5.98%	5.84%	4.60%	4.58%	4.95%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Status:	**05/31/2012**	**06/30/2012**	**07/31/2012**	**08/31/2012**	**09/30/2012**	**10/31/2012**	**11/30/2012**
Against Medical Advice (AMA)	24	13	19	10	13	8	12
Left After Medical Screening (LMS) - E	12	9	8	13	7	8	8
Left Prior to Triage (LPT) - E	24	14	16	10	21	20	18
Left Without Being Seen (LWBS) - E	33	26	19	29	37	42	23
Admitted	183	184	175	153	135	142	139
Admitted - BHU	-	-	-	-	-	-	3
Admitted - ICU	6	4	2	2	13	21	24
Admitted - OR	10	14	6	14	13	13	12
Courtesy Visit - E	43	30	40	33	24	26	25
Discharged	85	118	73	90	24	24	12
Discharged - Home	1,400	1,243	1,346	1,384	1,480	1,501	1,401
Discharged - Jail	9	13	10	9	9	5	5
Discharged - NH	23	28	17	14	20	19	23
Error - E	10	15	15	15	13	14	10
Expired	3	4	4	1	4	1	2
Transferred	42	46	54	60	41	53	52
Total	**1,907**	**1,761**	**1,804**	**1,837**	**1,854**	**1,897**	**1,769**

Rationale:

Over 85% of the visits to the Emergency Room are for Level 3 or lower based on the Emergency Severity Index (ESI). Each patient is assessed based upon the following criteria:

1. **Level 1** – Patients that require immediate attention of life threat to airway, breathing, circulation or disability (mental status) or in need of emergent life-saving intervention. The patient is unstable.
2. **Level 2** – Patients who have a high risk situation presents confused/ lethargic/disoriented or in severe pain/distress > or equal to 97/0-10 scale) in the context of organ/tissue loss or severe emotional or psychological distress.
3. **Level 3** – Patients who require two or more resources to reach a disposition decision.
4. **Level 4** – Patients who require one resource to reach a disposition decision.
5. **Level 5** – Patients who require no resources to reach a disposition decision.

All patients to the Emergency Room will benefit from improved patient flows as of the result of the RME. Based on the results of our community survey in 2012, our community has noted improvements needed in the Emergency Room setting to improve access for their needs. In addition, low patient satisfaction scores in the Emergency Room over the past few years is another justification for required changes in this area to address the needs of our community. The implementation of the RME will impact each of these concerns.

Community Needs:

All required components of this project will be addressed by this endeavor and are needed in this region. The implementation of RME addresses the Region's Community Needs related to CN.5 – Inappropriate emergency department utilization.

Related Category 3 Outcome Measures:

The expected results of the implementation of RME is to ensure the appropriate level of care improving the patient satisfaction of all users in the Emergency Room. To demonstrate this, TRMC has selected one Related Category 3 Outcome Measure:

OD – 6 Patient Satisfaction

IT – 6.1: *Percent improvement over baseline of patient satisfaction scores.*

(1) *Establish if patients are getting timely care, appointments, and information.*

Relationship to Other Projects and Measures:

All of the projects of TRMC complement each other to meet the transformational goals and the three aims of CMS. Expansion of primary care access, improved access to specialty care, reduction in expenses through cost containment and the implementation of a Rapid Medical Exam in the ED are consistent with each other and complement the goals of each project.

Relationship to Other Performing Projects in the RHP1:

Ensuring the appropriate level of care is a major initiative of the entire region. Many of the other regional partners have selected projects which have components of appropriate level of care in their goals and milestones. The geographic area covered in RHP Plan for this region

lends itself to multiple entities expanding primary care. It is our full intention to participate and lead some of the learning collaborative opportunities to share best practices.

Plan for Learning Collaboratives:
Learning collaboratives are essential to the success of high quality health systems that achieve the highest level of performance. TRMC believes in and supports the value of learning collaborative and plans to support the plans of Region 1. The system pledges to develop, support, participate, and lead the effort to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in the region. Our goal is to have our collaboratives inform others of our experiences and best practices acquired and learn from others in the state. Already, some small groups with similar hospitals, including Hunt Regional Medical Center, Hopkins County Memorial Hospital, TRMC, and Mother Frances Hospital, have met to discuss the project planning process and selection of projects.

Project Valuation:
Appropriate level of care is critical to ensure the patient's Emergency Room experience is efficient and cost effective. In our current patient flow, resources are not adequately proportioned in a cost effective manner. The implementation of the RME will allow our Emergency Room personnel to staff for the appropriate level of care improving our cost effectiveness. Assuming the modification to the RME flow improved the cost for the appropriate level of care by 2.5%, the annual savings would be approximately $234,000:

Savings - RME Patient Flow	
Total ED Visits (annual)	21,993
Avg Level 3 or Below	85%
ED Visits Impacted	18,694
Average ED Visit	$500
Estimated ED Charges	$9,346,843
% Savings - RME Flow	2.5%
Estimated Annual Savings	**$233,671**

The chart above calculates annual savings of at least $234,000 per year. Accordingly, TRMC's average DSRIP funding request of approximately $151,924 per year (including Category 2 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

138913209.2.2	2.8.1 A-F	2.8.1 A-F	2.8 – *APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY*	
	Titus Regional Medical Center			138913209
Related Category 3 Outcome Measure:	*138913209.3.5*	***IT-6.1 (1)***	Percent improvement over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information.	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: 2.8.1 A-F P-1: Target specific workflows, processes and/or clinical areas to improve. **Metric 2.8.1 A-F P-1.1:** Performing Provider review and prioritization of areas or processes to improve upon. **Baseline/Goal:** Submission of Performing Provider Report. **Data Source:** Notes of meetings, analysis of assigned teams, proposals for improved RME. **Milestone 1 Estimated Incentive Payment (*maximum amount)*: $121,284**	**Milestone 2 2.8.1 A-F I-14**: Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in patient time to provider from baseline. **Baseline/Goal:** Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 2 Estimated Incentive Payment: $42,298** **Milestone 3 2.8.1 A-F I-14**: Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in patient turn-around time for discharged patients from baseline. **Baseline/Goal:**		**Milestone 5 2.8.1 A-F I-14**: Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in patient time to provider from baseline. **Baseline/Goal:** Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 5 Estimated Incentive Payment: $43,026** **Milestone 6 2.8.1 A-F I-14**: Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in patient turn-around time for discharged patients from baseline. **Baseline/Goal:** Emergency Room statistics from May	**Milestone 8 2.8.1 A-F I-14**: Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in patient time to provider from baseline. **Baseline/Goal:** Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 8 Estimated Incentive Payment: $34,991** **Milestone 9 2.8.1 A-F I-14**: Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in patient turn-around time for discharged patients from baseline. **Baseline/Goal:**

138913209.2.2	2.8.1 A-F	2.8.1 A-F	2.8 – *APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY*	
Titus Regional Medical Center				138913209
Related Category 3 Outcome Measure:	*138913209.3.5*	***IT-6.1 (1)***	Percent improvement over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information.	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 3 Estimated Incentive Payment: $42,298** **Milestone 4 2.8.1 A-F I-14:** Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in percentage of patients who leave without being seen compared to baseline. **Baseline/Goal:** Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 4 Estimated Incentive Payment: $42,298**		1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 6 Estimated Incentive Payment: $43,026** **Milestone 7 2.8.1 A-F I-14:** Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in percentage of patients who leave without being seen compared to baseline. **Baseline/Goal:** Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 7 Estimated Incentive Payment: $43,026**	Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 9 Estimated Incentive Payment: $34,991** **Milestone 10 2.8.1 A-F I-14:** Measure efficiency and/or cost. **Metric 2.8.1 A-F I-14.1:** Decrease in percentage of patients who leave without being seen compared to baseline. **Baseline/Goal:** Emergency Room statistics from May 1, 2012 through December 31, 2012. **Data Source:** Emergency Room Monthly Data Report. **Milestone 10 Estimated Incentive Payment: $34,991**

138913209.2.2	**2.8.1 A-F**	**2.8.1 A-F**	**2.8 – *APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY***
Titus Regional Medical Center			138913209
Related Category 3 Outcome Measure:	*138913209.3.5*	***IT-6.1 (1)***	Percent improvement over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information.

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $121,284	**Year 3 Estimated Milestone Bundle Amount: $126,894**	**Year 4 Estimated Milestone Bundle Amount: $129,078**	**Year 5 Estimated Milestone Bundle Amount: $104,972**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $482,228			

Project Option: 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID Number: 139173209.2.1 (PASS 1)
Performing Provider Name/TPI: ETMC Athens 139173209

Project Abstract

Provider: East Texas Medical Center Athens (ETMC) is a 117-bed, full-service hospital dedicated to serving the Henderson County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Henderson County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 258,782.
Intervention: This project is to implement a patient navigation service that shifts non-urgent patients to a more appropriate level of care. The patient navigators will provide non-urgent patients with a referral to a primary care provider.
Need for the Project: Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.
Target Population: The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to refer an average of 1,450 new primary care clinic patients each year with a Medicaid and indigent share of 30%.
Category 1 or 2 Expected Patient Benefits: ETMC expects to refer 17% of non-urgent patients without a primary care provider to a primary care provider while in the ED by DY 5, an estimated 2,466 patients. Patients will benefit from access to a primary care provider and follow-up care.
Category 3 Outcomes: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

Project Narrative

Project Description: The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. ETMC's 4-year goal is to refer 17% of the non-urgent emergency room patients without a primary care provider to a primary care provider while in the ED.

Through our Patient Navigation Program, ETMC proposes to implement ED triage protocol that shifts non-urgent patients to the more appropriate clinic setting. In this program, ETMC proposes to implement a more stringent medical screening process designed to transition non-urgent patients—those contained in the Level IV Semi-urgent and Level V Non-urgent categories—to the clinic setting. Medical screenings will continue to be performed on 100% of ED patients; however, the more detailed protocol will provide a method to identify non-urgent patients that would benefit from a more appropriate primary care visit. These screenings would be conducted by a patient navigator (physician assistant or registered nurse).

Consistent with the overarching goal and vision of RHP 1, ETMC Athens is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is an area where patients face many challenges in accessing primary care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC Athens is proposing to expand primary care capacity. Expanding primary care access meets several community needs outlined by RHP 1, including: insufficient access to primary care services (CN.1), high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

ETMC will deploy registered nurses or nurse practitioners as patient navigators to identify frequent ED users. We will use navigators as part of a preventable ED reduction program that connects patients to primary and preventive care. Referring patients to primary care providers will increase access to care management and/or chronic care management, including education in chronic disease self-management. Finally, ETMC will conduct quality improvement methods for the project to identify project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project. These meaningful quality improvement activities are essential to the success of implementing our project and achieving Category 3 outcome measures.

Starting Point/Baseline: ETMC has the need to implement a navigation program that uses ED triage protocol to shift non-urgent patients to the more appropriate clinic setting. ETMC saw approximately 35,741 emergency room visits in 2012—including 14,506 non-urgent visits (40.6%). While ETMC triages 100% of its ED patients, it currently does not screen any non-urgent patients to the more appropriate clinic setting.

2012 ETMC Athens		
Level of Care	**ED Visits**	**Percent**
Unknown	129	0.4%
1 Resuscitation	114	0.3%
2 Emergent	4,662	13.0%
3 Urgent	16,330	45.7%
4 Semi Urgent	12,187	34.1%
5 Non Urgent	2,319	6.5%
Grand Total	**35,741**	**100.0%**
Percent Non-Urgent	14,506	40.6%

Rationale: According to the 2009 National Hospital Ambulatory Medical Care Survey, approximately 43% of ED visits are non-urgent and can be seen in a primary care clinic. The national survey and our regional community needs assessment (CN.1 and CN. 5) indicate that these patients need to be seen in a more appropriate care setting in order to improve quality and decrease the cost of care. Shifting this volume to the clinic setting will establish a place to receive needed follow up care while reducing additional ED visits and inpatient admissions.

An article published in Health Affairs, a peer-review healthcare journal, suggests the overutilization of emergency departments as a source of primary care. The study's "data indicate[s] that more than half of acute visits today involve a doctor other than the patient's personal physician. More than a quarter of all acute care visits—including virtually all weekend and 'after hours' encounters—occur in hospital emergency departments. Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients' ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. (Pitts et al.)."

The expected outcome is to have an increase in patients referred to a primary care visit, which translates to more effective care delivery, higher clinic utilization, and lower ED cost. Not only does navigation provide better care to the non-urgent patients, but it also allows ETMC to provide better quality of care to urgent patients. The Health Affairs article suggests that a packed waiting room complicates efforts to treat every patient in an appropriate time frame. With a less crowded waiting room, ED resources can be better utilized to give more attention to urgent needs while facilitating more efficient care for clinically appropriate visits.

Patient navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the most prevalent types of services provided will allow ETMC to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient education services and peer support networks. The purpose of the program is to identify those patients who are clinic appropriate and immediately transfer them to an onsite ETMC physician clinic where they can receive care in a clinically appropriate, less costly setting.

(Pitts, S.R.; Carrier, E.R.; Rich, E.C.; & Kellermann, A.L. (2010). Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 29:9, 1620-1629.)

Related Category 3 Outcome Measures: The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5.

We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care.

The previously stated project description and rationale further describes how implementing the patient care navigators and ED triage protocol will prevent future ambulatory care sensitive admissions.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (139173209.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. ETMC Athens will establish a new primary care on the campus (139173209.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

In addition to the newly established Athens clinic, there is also a need for primary care physicians in the area. We plan to recruit 4 primary care physicians which will be (139173209.1.2) to increase the overall access to primary care throughout the Athens community.

The combination of these primary care projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (139173209.3.1-3) due to enhanced physician-patient relationships and preventive care.

Moreover, expanding care transitions programs (139173209.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will improve outcomes and decrease 30 day readmissions (139173209.3.4). Redesigning to improve the patient experience (139173209.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction (139173209.3.5). We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar patient navigation projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic of near $1.3M per year. Accordingly, ETMC's average DSRIP funding request of approximately $1.2M per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic	
Total ED Visits (non-urgent)	14,506
% Clinic Appropriate	17%
Clinic Appropriate Patients	2,466
Avg ED Facility Payment	$ 550
Avg ED Professional Payment	$ 125
Estimated ED Savings	**$ 1,665,525**
Clinic Payment @ 78% savings	$ 366,416
Total Estimated Savings	**$ 1,299,110**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

139173209.2.1	***2.9.1***	***2.9.1.A-E***	**Establish a Patient Care Navigation Program**
ETMC Athens			*139173209*
Related Category 3 Outcome Measure(s):	***139173209.3.3***	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.9.1.P-5 Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. **Metric: 2.9.1.P-5.1** Collect and report on all the types of patient navigator services provided. (i.e. primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks) **Baseline/Goal:** Report on all the types of patient navigator services provided **Data Source**: Patient Encounter Data **Milestone 1 Estimated Incentive Payment:** $966,286	**Milestone 2: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 5% [725] out of a baseline of 14,506 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 2 Estimated Incentive Payment:** $1,054,166	**Milestone 3: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 10% [1,450] out of a baseline of 14,506 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 3 Estimated Incentive Payment:** $1,057,231	**Milestone 4: 2.9.1.I-6** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Metric: 2.9.1.I-6.3** Percent of non-urgent patients without a primary care provider who were referred to a primary care provider in the ED Numerator: Number non-urgent ED patients without a PCP documented in their medical record that receive (documented) referral to a PCP. Denominator: Non-urgent ED patients without a PCP documented in their medical record. **Baseline/Goal:** Refer 17% [2,466] out of a baseline of 14,506 non-urgent patients **Data Source**: Patient Encounter Data **Milestone 4 Estimated Incentive Payment:** $873,365
Year 2 Estimated Total DSRIP: $966,286	Year 3 Estimated Total DSRIP: $1,054,166	Year 4 Estimated Total DSRIP: $1,057,231	Year 5 Estimated Total DSRIP: $873,365
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$3,951,048***			

Project Option: 2.12.1 – Develop, implement, and evaluate standardized clinical protocols and evidence based care delivery model to improve care transitions
Unique Project ID Number: 139173209.2.2 (Pass 1)
Performing Provider Name/TPI: ETMC Athens 139173209

Project Abstract

Provider: East Texas Medical Center Athens (ETMC) is a 117-bed, full-service hospital dedicated to serving the Henderson County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Henderson County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 258,782.

Intervention: This project is to implement the re-engineered discharge (RED) design for congestive heart failure (CHF) patients. Newly established discharge protocol will create smooth transitions of care from inpatient to outpatient settings by providing care management during this time period.

Need for the Project: As sited in the community needs assessment (CN.3, CN.4, and CN.6), our region has high rates of chronic disease, high costs due to potentially preventable hospitalizations, and needs improvement with efficiency in and effectiveness of health care delivery. A delivery model to improve CHF care transitions is needed to ensure progress in these areas.

Target Population: The target population is ETMC Athens' inpatients with a diagnosis of CHF. We expect to serve approximately 197 CHF patients per year with a Medicaid and indigent share of 30%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve adherence to new CHF care transition processes, evidenced by a 20% increase over baseline by DY 5. Patients will benefit from improved discharge planning and evidence-based, follow-up care.

Category 3 Outcomes: The goal of implementing the re-engineered discharge (RED) design is to reduce potentially preventable readmissions (IT-3.2). The primary outcome measure that will demonstrate our success toward that goal is to decrease the CHF 30 day re-admission rate by 8% over baseline.

Project Narrative

Project Description: Our goal is to reduce potentially preventable readmissions by implementing the re-engineered discharge (RED) design. Focusing on congestive heart failure (CHF) patients, the protocol will create smooth transitions of care from inpatient to outpatient settings by providing care management during this time period. The four year target goal is to improve adherence to new CHF care transition processes by 20% over baseline (DY 3).

ETMC will create and implement discharge care protocols for CHF patients—much like the AHRQ designed protocol utilized in Project RED. The three core elements of Project RED are the assignment of discharge advocates, the development of a specific after-hospital care plan (AHCP), and follow-up phone calls to the patient's home.

Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to decrease CHF readmissions through improved discharge planning. Decreasing readmissions meets several community needs outlined by RHP 1, including: high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4) and efficiency in and effectiveness of health care delivery (CN.6).

Our care transitions project will incorporate the required core components, including: review best practices from a range of models; conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool and patient interviews; integrate information systems so that continuity of care for patients is enabled; develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days; implement discharge planning program and post discharge support program; develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers; and conduct quality improvement using by identifying project impacts and "lessons learned."

Starting Point/Baseline: While ETMC Athens' case management department educates patients on discharge planning and medicine reconciliation, there is not a comprehensive process that includes post-discharge phone calls to inquire about their symptoms and confirm a follow-up clinic appointment. ETMC has explored RED protocol through webinar and seminar attendance and has begun a focus on monitoring readmissions by diagnosis. The case management department has also recently focused on discharge planning improvement and measuring progress through the core measure chart reviews for CHF discharge instructions. When applying national readmission rates, ETMC Athens has an approximate 197 annual CHF readmissions within 30 days of discharge for FY2012.

Rationale: According to AHRQ, almost one-third of CHF patients are readmitted within 30 days of discharge. A 2010 AHRQ study reports that the average cost of CHF readmission is $13,000 with Medicare expending $880 million annually. Although research suggests that guideline-based management of heart failure can prevent hospitalizations, AHRQ reports that many hospitals do not consistently follow these guidelines. Patients leave the hospital not

understanding why they were admitted, what was done for them in the hospital, and how to care for themselves once released. In particular, patients often leave not knowing what medicines they should and should not be taking, what symptoms to look out for, and who to contact for problems. This lack of knowledge frequently causes patients to be readmitted, causing needless suffering and preventable health care costs.

As sited in the community needs assessment (CN.4), implementing new discharge protocol will decrease the high cost of readmissions for CHF patients. The three core elements of a discharge advocate, the AHCP, and the follow-up phone call will provide patient-centered education, comprehensive discharge planning, and post-discharge reinforcement in a practical and easily applied method. Creating a coordinated transition from inpatient service to home will have multiple benefits to patient experience and safety. With timely and quick post-hospital stay follow-up, problems with understanding and deterioration in clinical health status can be quickly identified and addressed, in most cases over the phone. For patients who have been recently hospitalized, the lack of follow-up appointments and information regarding how to keep themselves healthy puts them at risk for readmission. Reducing expensive and unnecessary readmissions will free resources for care at more appropriate levels.

When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Patients cannot fully participate in their care during and after hospital stays without sufficient understanding of their diagnoses, medication, and self-care needs. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home and community-based services.

Related Category 3 Outcome Measures: The goal of implementing this project is to reduce potentially preventable readmissions (IT-3.2) by implementing the re-engineered discharge (RED) design. Focusing on congestive heart failure (CHF) patients, the protocol will create smooth transitions of care from inpatient to outpatient settings by providing care management during this time period.

The primary outcome measure that will demonstrate our success toward that goal is to decrease the CHF 30 day re-admission rate by 8% over baseline.

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (139173209.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. ETMC Athens will establish a new primary care on the campus (139173209.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

In addition to the newly established Athens clinic, there is also a need for primary care physicians in the area. We plan to recruit 4 primary care physicians which will be (139173209.1.2) to increase the overall access to primary care throughout the Athens community.

The combination of these primary care projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (139173209.3.1-3) due to enhanced physician-patient relationships and preventive care.

Moreover, expanding care transitions programs (139173209.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will improve outcomes and decrease 30 day readmissions (139173209.3.4). Redesigning to improve the patient experience (139173209.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction (139173209.3.5). We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: A trial study published by the *Annals of Internal Medicine* and the National Institutes of Health on the re-engineered hospital discharge program shows a significant reduction in readmissions and cost. The trial hospital realized a 34% lower total cost of care for the RED intervention group of patients. "The RED intervention [also] decreased hospital utilization (combined emergency department visits and readmissions) within 30 days of discharge by about 30%. More intervention group participants reported seeing their PCP for follow-up within 30 days and reported higher levels of preparedness for discharge. In addition, the intervention was successful in reducing hospital utilization among participants who frequently used hospital services." The estimated annual cost savings for CHF patients is shown below:

Estimated Savings from CHF Post-Discharge Support	
Annual CHF Admissions	655
% CHF Readmissions*	30%
CHF Readmissions	197
Cost per CHF Readmission*	$ 13,000
Cost of CHF Readmissions	**$ 2,554,500**
% Decrease in Readmissions	10%
Prevented Readmissions	20
Estimated Annual Savings	**$ 255,450**

* AHRQ

(Jack MD, Brian W., et al (2009). Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. *Annals of Internal Medicine*, 150(3), 178-187.)

139173209.2.2	***2.12.1***	***2.12.1A-G***	***Implement/Expand Care Transitions Programs***
ETMC Athens			*139173209*
Related Category 3 Outcome Measure(s):	***139173209.3.4***	*3.IT-3.2*	*Congestive Heart Failure 30 day re-admission rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.12.1.P-1 Develop or implement best practices or evidence-based protocols to improve adherence to discharge and follow-up care instructions. **Metric: 2.12.1.P-1.1** Care transitions protocols. **Baseline/Goal:** Work to develop program and related protocols. **Data Source**: Documentation **Milestone 1 Estimated Incentive Payment:** $ 214,056	**Milestone 2: 2.12.1.I-11** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. **Metric: 2.12.1.I-11.1** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for care transition services. **Baseline/Goal:** Establish a baseline for patients in target population who receive transition protocol. We estimate that baseline to be 197 patients who have CHF. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 2 Estimated Incentive Payment:** $ 233,524	**Milestone 3: 2.12.1.I-11** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. **Metric: 2.12.1.I-11.1** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for care transition services. **Baseline/Goal:** 10% (20) increase in number of patients who receive the transition protocol over baseline of 197. **Data Source**: Registry, EHR, claims or other Performing Provider source **Milestone 3 Estimated Incentive Payment:** $ 234,203	**Milestone 4: 2.12.1.I-11** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. **Metric: 2.12.1.I-11.1** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for care transition services. **Baseline/Goal:** 20% (40) increase in number of patients who receive the transition protocol over baseline of 197. **Data Source:** Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment:** $ 193,472
Year 2 Estimated Total DSRIP: $ 214,056	Year 3 Estimated Total DSRIP: $ 233,524	Year 4 Estimated Total DSRIP: $ 234,203	Year 5 Estimated Total DSRIP: $ 193,472
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* **$ 875,255**			

Project Option: 2.4.1 – Implement processes to measure and improve patient experience
Unique Project ID Number: 139173209.2.3 (Pass 1)
Performing Provider Name/TPI: ETMC Athens 139173209

Project Abstract

Provider: East Texas Medical Center Athens (ETMC) is a 117-bed, full-service hospital dedicated to serving the Henderson County area with advanced diagnostics, medical and surgical care, obstetrical services, and a Level IV trauma center. ETMC's primary service area is Henderson County, but the secondary service area extends to surrounding counties. The total service area population is estimated at around 258,782.

Intervention: This project is to develop and implement a patient experience improvement plan in order to improve how the patient experiences care and the patient's satisfaction with the care provided.

Need for the Project: As sited in the community needs assessment (CN.4 and CN.6), high costs due to potentially preventable hospitalizations and efficiency in and effectiveness of health care delivery are needs in Northeast Texas. Improved patient satisfaction is linked to better outcomes and prevented readmissions while providing care in a more effective efficient manner.

Target Population: The target population is any person admitted to ETMC Athens as an inpatient. We expect to serve approximately 6,680 patients per year with a Medicaid and indigent share of 30%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve patient experience scores, as evidenced by reaching the 60th percentile in overall HCAHPS scores by DY 5. Patients will benefit from efficient and effective care focused on the patient's overall experience.

Category 3 Outcomes: The related category 3 outcome measure is to improve how the patient experiences the care and the patient's satisfaction with the care provided. The primary outcome measure that will demonstrate our success is to increase the facilities "overall" HCAHPS score to the 60th percentile by DY 5 as measured by an objective outsource vendor.

Project Narrative

Project Description: ETMC Athens' goal is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, ETMC is targeting long term improvement in HCAHPS scores through the implementation of a facility wide, transformative program. Accordingly, the DY 5 target goal is to increase overall HCAHPS scores to above the 60th %ile as measured by an objective outsource vendor.

In a broad sense, ETMC is proposing nothing short of cultural transformation aimed at improving patient satisfaction. On a more specific level however, there are 3 significant programmatic interventions that will enable such a transition:

- Infrastructure development: ETMC Athens is proposing the development on an extensive infrastructure investment aimed at identifying, improving, tracking and maintaining organization-wide improvements.

- Administrative rounding program: ETMC Athens plans to expand and enhance current patient satisfaction rounding efforts. While the goal is to see every patient, every day, such a rounding program will also seek to fix patient satisfaction issues such as those described in HCAHPS in real time.

- Improve the hospital discharge process: ETMC Athens is exploring a number of ways to enhance the discharge and immediate post discharge process. For example, ETMC has employed a limited patient callback program in the past and had some measureable success in improving the satisfaction of those patients. This and similar programs will be significantly expanded to cover a wider range of patients.

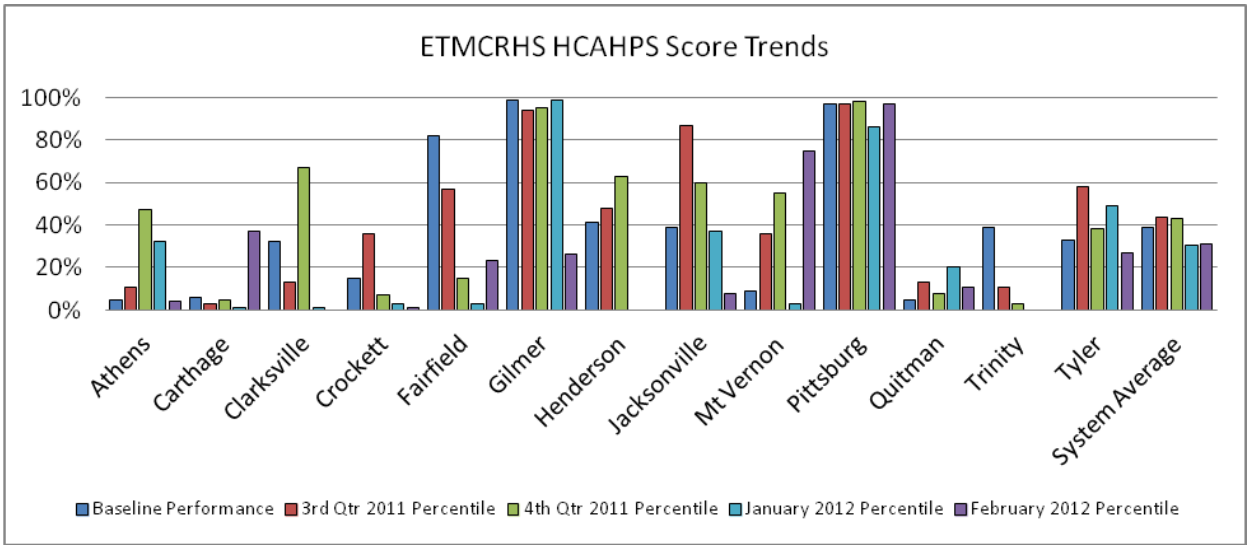
Consistent with the overarching goal and vision of RHP 1, ETMC is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of ETMC. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, ETMC is proposing to improve the patient experience and decrease readmissions through improved discharge planning. Improving patient experience and decreasing readmissions meets several community needs outlined by RHP 1, including: high costs due to potentially preventable hospitalizations (CN.4) and efficiency in and effectiveness of health care delivery (CN.6).

Finally, in implementing these programs, ETMC will incorporate the following project components: **a)** Organizational integration and prioritization of patient experience **b)** Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience; **c)** Implementing processes to improve patient's experience in getting through to the clinical practice; **d)** Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Starting point/Baseline: Historically, ETMC's system hospitals have had a difficult time in achieving consistency in patient satisfaction across entities and sustaining high levels of patient

satisfaction over time. As shown in the chart below, over the past 4 reporting quarters, ETMC Athens has had an average aggregate HCAPS score of below the 20th percentile. ETMC Athens' goal will be to achieve 60%ile performance over time.



Rationale: Like many regional healthcare systems, ETMC is faced with the challenge of standardizing care across 14 hospitals, more than 1000 physicians in a service area that exceeds 44,000 square miles. Texas RHP 1's community needs assessment (CN.6) found a significant need for improvement in efficiency and effectiveness of healthcare delivery. ETMC Athens is the system's second largest hospital—offering a full continuum of healthcare services and extending ETMC's healthcare access to the Athens community. In other areas such as patient satisfaction programs, however, the ETMC hospitals have been more independent in their approach.

The real challenge for a regional system like ETMC is to identify pockets of innovation in the system that are dramatically improving quality, cost and satisfaction and transport those findings and processes around the system. A recent article suggests that one way to improve cost, quality and satisfaction is to develop more rigorous discharge processes, especially in the area of medication reconciliation and patient education. Dr. Clancy's article and other research also cite myriad programmatic interventions from around the country that aim to improve quality, cost and satisfaction.

Clancy, "Reengineering the Hospital Discharge Process: A protocol to improve patient safety, reduce cost and boost patient satisfaction." American Journal of Medical Quality, July/August 2009 vol 24, no. 344-346.

Related Category 3 Outcome Measures: The goal of implementing the patient care experience project (139173209.2.3) is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, ETMC is targeting long term improvement in HCAHPS scores through the implementation of a facility wide, transformative

program. The primary outcome measure that will demonstrate our success toward that goal is to increase the facility's "overall" HCAHPS score by 10% over baseline by DY 5 as measured by an objective outsource vendor (139173209.3.5).

Relationship to Other Projects: ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (139173209.2.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost.

The non-urgent patients will need to be referred to an available clinic. ETMC Athens will establish a new primary care on the campus (139173209.1.1) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population.

In addition to the newly established Athens clinic, there is also a need for primary care physicians in the area. We plan to recruit 4 primary care physicians which will be (139173209.1.2) to increase the overall access to primary care throughout the Athens community.

The combination of these primary care projects will improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (139173209.3.1-3) due to enhanced physician-patient relationships and preventive care.

Moreover, expanding care transitions programs (139173209.2.2) by establishing new discharge protocols and implementing Project RED for cardiac patients will improve outcomes and decrease 30 day readmissions (139173209.3.4). Redesigning to improve the patient experience (139173209.2.3) is our final project that unites all the other efforts by improving overall patient satisfaction (139173209.3.5). We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: ETMC has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: ETMC plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: ETMC's implementation of a rigorous patient satisfaction improvement program is expected to have a measureable impact on patient safety, quality and cost. As

described in the matrix below, the best aggregate measure of these items will be a system-wide improvement in percentile ranking of patient satisfaction scores at all facilities.

One specific impact of improved patient satisfaction is in the area of improving the hospital discharge process. Research in this area suggests that improved medication reconciliation, and post discharge follow-ups may have an impact on downstream re-admissions for certain target populations.

As shown in the table below, a modest 10% decrease in readmission rate for Medicare patients (i.e. from 18% to 16.2%) could be mean a savings of as much as $1.154M to the Medicare Program. Accordingly, ETMC's average DSRIP funding request of approximately $625k per year (Category 2 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

Estimated Savings from Patient Experience Improvement	
Annual Discharges	6680
% Medicare Readmissions*	18%
Readmissions	1202
Medicare Cost per Readmission*	$ 9,600
Cost of Readmissions	**$ 11,543,040**
% Decrease in Readmissions	10%
Prevented Readmissions	120
Estimated Annual Savings	**$ 1,154,304**

* AHRQ

139173209.2.3	***2.4.1***	***2.4.1.A-D***	***IMPROVE PATIENT CARE EXPERIENCE***
ETMC Athens			*139173209*
Related Category 3 Outcome Measure(s):	***139173209.3.5***	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores.*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.4.1.P-2 Write and disseminate a patient/family experience strategic plan. **Metric: 2.4.1.P-2.1** Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization **Baseline/Goal:** Submit the plan. **Data Source**: Documentation **Milestone 1 Estimated Incentive Payment:** $490,553	**Milestone 2: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Establish baseline as overall percentile ranking compared to comparably sized hospitals. Athens baseline HCHAPS score has been below the 20th percentile. **Data Source**: As reported by Press Ganey or similar national company **Milestone 2 Estimated Incentive Payment:** $535,167	**Milestone 3: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Achieve 55th %ile **Data Source**: As reported by Press Ganey or similar national company. **Milestone 3 Estimated Incentive Payment:** $536,723	**Milestone 4: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Achieve 60th%ile. **Data Source**: As reported by Press Ganey or similar national company. **Milestone 4 Estimated Incentive Payment:** $443,380
Year 2 Estimated Total DSRIP: $490,553	Year 3 Estimated Total DSRIP: $535,167	Year 4 Estimated Total DSRIP: $536,723	Year 5 Estimated Total DSRIP: $443,380
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$2,005,823***			

Project Option: 2.6.2 – Establish self-management programs and wellness using evidence-based designs
Unique Project ID Number: 177870603.2.1 (PASS 2)
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Project Abstract

Provider: Red River Regional Hospital (RRRH) is a 25-bed critical access hospital that provides inpatient, outpatient, and emergency services to its communities. RRRH's primary service area is Fannin County, but the secondary service area extends to surrounding communities. The service area population is estimated at around 33,915.

Intervention: This project is to develop and implement an evidence-based diabetes management program and increase the percentage of diabetic clinic patients receiving the innovative intervention.

Need for the Project: As sited in the community needs assessment (CN.3), there is a critical shortage of access to chronic disease management. There is a great need for an evidence-based program to help patients manage their diabetes.

Target Population: The target population is service area residents that currently do not have sufficient access to chronic disease management. We expect to serve an average of 298 clinic patients with a Medicaid and indigent share of at least 15%.

Category 1 or 2 Expected Patient Benefits: The project seeks to implement a diabetes management program and improve the health of RRRH clinic patients, as evidenced by 325 diabetic clinic patients receiving the intervention by DY 5. Patients will benefit from expanded access to diabetes management.

Category 3 Outcomes: The related category 3 outcome measure is to decrease HbA1c poor control (>9.0%) patients in the RRRH clinic. RRRH plans to decrease the percentage of HbA1c poor control (>9.0%) patients—RRRH clinic patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: Red River Regional Hospital's goal is to be able to increase the percentage of diabetic clinic patients receiving innovative intervention consistent with evidence-based model. Red River Regional Hospital plans to implement an evidence-based health promotion program to provide health education and care management for diabetic patients in the RRRH clinic. The DY 5 goal is to see 325 diabetic clinic patients receiving intervention.

Self Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient

education offers information and technical skills, self management education teaches problem solving skills. A central concept in self management is self efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self efficacy is enhanced when patients succeed in solving patient identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self management skills are more effective than information only patient education in improving clinical outcomes; (2) in some circumstances, self management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

Consistent with the overarching goal and vision of RHP 1, RRRH is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of RRRH. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, RRRH is proposing to implement a diabetes management program for clinic patients. Improving diabetes management meets several community needs outlined by RHP 1, including: high rates of chronic disease (CN.3), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency department utilization (CN.5).

Starting point/Baseline: A study by The American Journal of Managed Care says that much of the suffering and cost associated with diabetes could be mitigated with appropriate care. However, fewer than 45% of persons with diabetes receive recommended care. This care gap is due to many factors such as inconsistent quality care from healthcare providers, lack of patient education, and lack of support for self-management such as meal planning, weight control, exercise, glucose monitoring, smoking cessation, and medication adherence. Disease management is designed to fill many of the care gaps. As the percentage of patients with diabetes continues to grow, RRRH sees the need to establish a diabetes management program to serve the East Texas community. This is increasingly important as several studies have shown that diabetes disease management programs effectively reduce hospital utilization and cost in various segments of the population.

Rationale: Diabetes is a disease that has reached epidemic proportions across the US and Texas. According to the Kaiser Family Foundation, 9.8% of adults in Texas have been diagnosed with diabetes while 6.2% of all US adults have diabetes. According to the Centers for Disease Control (CDC) in Atlanta, diabetes was the sixth leading cause of death on U.S. death certificates in 2006. Overall, the risk for death among people with diabetes is about twice that of people without diabetes of similar age. Diabetes is also the leading cause of new cases of blindness, kidney failure, and non-traumatic lower-extremity amputations among adults.

As sited in the community needs assessment (CN.3), establishing self-management programs and wellness using evidence-based designs will help manage chronic disease. Diabetes is one of the most costly and prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country $100 billion annually. In addition, diabetes accounts for nearly 20% of all deaths in people over 25 years. Amputation, blindness, and kidney failure can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

If current trends continue, 1 in 3 Americans will develop diabetes sometime in their lifetime, and those with diabetes will lose an average of 10-15 years of life. African American, Hispanic, American Indian, and Alaska Native adults are twice as likely as white adults to have diabetes. Therefore, the large Hispanic population is at risk throughout the East Texas communities. The diabetes epidemic is only getting worse, so implementing the diabetes management program is essential to serving the health needs of East Texas.

Related Category 3 Outcome Measures: Red River Regional Hospital plans to engage in project planning for decreasing HbA1c poor control (>9.0%) patients in the clinic during DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for the percentage of HbA1c poor control (>9.0%) patients. RRRH plans to decrease the percentage of HbA1c poor control (>9.0%) patients —RRRH clinic patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Through expanded diabetes management access, our primary care clinic will decrease the percentage patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

Relationship to Other Projects: The RRRH clinic will begin offering extended hours and additional physician staffing (177870603.1.1) to provide expanded access to primary care and preventive services. The expansion of access to primary care providers will help patients manage chronic disease and improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (177870603.3.1) due to enhanced physician-patient relationships, preventive care, and chronic disease management.

Providing primary care to more patients through our extended hours and staffing will allow RRRH to make a significant impact in disease management. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2) and decrease the cost of acute inpatient care.

The structured outpatient program (SOP) for geriatric, behavioral health patients will improve the functional status of individuals receiving specialized interventions (177870603.2.3). Providing this outpatient program for geriatric, behavioral health patients will effectively decrease the 30 day readmission rate for the same population (177870603.3.4).

While clinic hours, staffing, and behavioral therapy reduce preventable admissions, redesigning to improve the patient experience (177870603.2.2) will improve overall patient satisfaction for inpatient admissions that could not be prevented. We will increase patient satisfaction scores (177870603.3.3) by implementing a mix of administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: RRRH has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Furthermore, our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP.

Plan for Learning Collaborative: RRRH plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: In a 2010 diabetes disease management study by The American Journal of Managed Care, the intervention group decreased their all-cause total medical costs by $984.87 per member per year (PMPY). They study's conclusion stated that "a disease management program for high-risk patients with diabetes and CAD was effective in reducing hospital inpatient admission and total costs in a Medicare Advantage population."

Applying this cost savings data, the chart below values diabetes management over $266,000 per year. Accordingly, RRRH's average DSRIP funding request of approximately $254,000 per year (including Category 2 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings from Diabetes Management	
Total Clinic Patients	2,761
% Diabetic Patients	9.8%
Clinic patients with diabetes	271
Annl. Savings per Diabetic patient*	$ 984.87
Estimated Annual Savings	**$266,498**

*American Journal of Managed Care

(Rosenzweig, et. al. Diabetes Disease Management in Medicare Advantage Reduces Hospitalizations and Costs. *The American Journal of Managed Care.* 2010;16(7):e157-e162)

177870603.2.1	***2.6.2***	***2.6.2***	**Implement Evidence-based Health Promotion Programs**
Red River Regional Hospital			***177870603***
Related Category 3 Outcome Measure(s):	***177870603.3.2***	*3.IT-1.10*	***Diabetes care: HbA1c poor control (>9.0%)***
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.6.2.P-2 Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. **Metric: 2.6.2.P-2.1** Document innovational strategy and plan. **Baseline/Goal:** Documentation of plan **Data Source**: Performing Provider evidence of innovational plan **Milestone 1 Estimated Incentive Payment:** $ 194,486	**Milestone 2: 2.6.2.I-6** Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. **Metric: 2.6.2.I-6.1** TBD by Performing Provider based on measure described above Numerator: Total number of patients in defined population who received innovative intervention. Denominator: Total number of patients in defined population. **Baseline/Goal:** Establish a baseline for diabetic clinic patients receiving intervention. We estimate the baseline to be approximately 271 patients. **Data Source**: Patient Records **Milestone 2 Estimated Incentive Payment:** $ 217,047	**Milestone 3: 2.6.2.I-6** Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. **Metric: 2.6.2.I-6.1** TBD by Performing Provider based on measure described above Numerator: Total number of patients in defined population who received innovative intervention. Denominator: Total number of patients in defined population. **Baseline/Goal:** 10% (27) increase in diabetic clinic patients receiving intervention over a baseline of 271. **Data Source**: Patient Records **Milestone 3 Estimated Incentive Payment:** $ 221,767	**Milestone 4: 2.6.2.I-6** Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. **Metric: 2.6.2.I-6.1** TBD by Performing Provider based on measure described above Numerator: Total number of patients in defined population who received innovative intervention. Denominator: Total number of patients in defined population. **Baseline/Goal:** 20% (54) increase in diabetic clinic patients receiving intervention over a baseline of 271. . **Data Source**: Patient Records **Milestone 4 Estimated Incentive Payment:** $ 184,513
Year 2 Estimated Total DSRIP: $ 194,486	Year 3 Estimated Total DSRIP: $217,047	Year 4 Estimated Total DSRIP: $221,767	Year 5 Estimated Total DSRIP: $184,513
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$817,813***			

Project Option: 2.4.1 – Implement processes to measure and improve patient experience

Unique Project ID Number: 177870603.2.2 (PASS 2)
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Project Abstract

Provider: Red River Regional Hospital (RRRH) is a 25-bed critical access hospital that provides inpatient, outpatient, and emergency services to its communities. RRRH's primary service area is Fannin County, but the secondary service area extends to surrounding communities. The service area population is estimated at around 33,915.

Intervention: This project is to develop and implement a patient experience improvement plan in order to improve how the patient experiences care and the patient's satisfaction with the care provided.

Need for the Project: As sited in the community needs assessment (CN.6), efficiency in and effectiveness of health care delivery is a need in Northeast Texas. Improved patient satisfaction is linked to better outcomes and prevented readmissions while providing care in a more effective efficient manner.

Target Population: The target population is any person admitted to RRRH as an inpatient. We expect to serve approximately 900 patients per year with a Medicaid and indigent share of 15%.

Category 1 or 2 Expected Patient Benefits: The project seeks to improve patient experience scores, as evidenced by reaching the 60th percentile in overall HCAHPS scores by DY 5. Patients will benefit from efficient and effective care focused on the patient's overall experience.

Category 3 Outcomes: The related category 3 outcome measure is to improve how the patient experiences the care and the patient's satisfaction with the care provided. The primary outcome measure that will demonstrate our success is to increase the facilities "overall" HCAHPS score by 10% over baseline as measured by an objective outsource vendor.

Project Narrative

Project Description: Red River Regional Hospital's goal is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, RRRH is targeting long term improvement in HCAHPS scores through the implementation of a facility wide, transformative program. Accordingly, the DY 5 target goal is to increase overall HCAHPS scores to the 60th %ile as measured by an objective outsource vendor.

In a broad sense, RRRH is proposing nothing short of cultural transformation aimed at improving patient satisfaction. On a more specific level however, there are 3 significant programmatic interventions that will enable such a transition:

- Infrastructure development: RRRH is proposing the development on an extensive infrastructure investment aimed at identifying, improving, tracking and maintaining organization-wide improvements. Though the specific of the program will be developed in DY2, examples of specific means by which the project core components will be implemented could include:

    - Addition of resources, both people and technology to perform concurrent chart review on targeted patient populations in order to ensure that clinical excellence on all patient populations is achieved and documented.
    - Development of methodologies and algorithms to identify root cause analysis of patient dissatisfaction. Such methodologies will require commitment of significant staff time and training in process improvement/LEAN type methodologies.
    - Dedication of leadership time, training and expertise in order to ensure that improvements are "baked into the culture."

- Administrative rounding program: RRRH plans to expand and enhance current patient satisfaction rounding efforts. While the goal is to see every patient, every day, such a rounding program will also seek to fix patient satisfaction issues such as those described in HCAHPS in real time. Though the specific of the program will be developed in DY2, examples of specific means by which the project core components will be implemented could include:

    - Working to develop an in depth targeted survey instrument for use during administrative rounding interactions
    - Develop a methodology for documenting "immediate improvement opportunities" and create a feedback loop methodology for customer interaction that demonstrates immediate improvements to patients.
    - Develop a staffing plan that provides for adequate time to complete administrative rounding activities.

- Improve the hospital discharge process: RRRH is exploring a number of ways to enhance the discharge and immediate post discharge process. For example, RRRH has employed a limited patient callback program in the past and had some measureable success in improving the satisfaction of those patients. This and similar programs will be significantly expanded to cover a wider range of patients. Though the specific of the program will be developed in DY2, examples of specific means by which the project core components will be implemented could include:

    - Working to develop an in depth targeted callback survey instrument for use during patient call back activities.
    - Develop a methodology for documenting "immediate improvement opportunities" and create a feedback loop methodology for customer interaction that demonstrates immediate improvements to patients.

- Develop a staffing plan that provides for adequate time to complete patient callback activities.

Consistent with the overarching goal and vision of RHP 1, RRRH is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of RRRH. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, RRRH is proposing to improve HCAHPS scores and decrease readmissions through improved discharge planning. Improving HCAHPS scores meets several community needs outlined by RHP 1, including: high costs due to potentially preventable hospitalizations (CN.4), inappropriate emergency department utilization (CN.5), and efficiency in and effectiveness of health care delivery (CN.6).

Finally, it is critical to reemphasize that it is RRRH's intention to address all core components that are listed in the DSRIP Menu including: **a)** Organizational integration and prioritization of patient experience **b)** Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience; **c)** Implementing processes to improve patient's experience in getting through to the clinical practice; **d)** Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Starting point/Baseline: While RRRH has not reported HCAHPS scores due to their critical access status, the hospital has measured its patient satisfaction scores over the past couple years. After implementing HCAHPS surveys and establishing a baseline, Red River Regional Hospital's goal will be to achieve 60%ile performance over time.

2012 Inpatient Satisfaction Scores											
Domain		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	YTD
I	Admission Process	85.4%	86.4%	79.2%	84.0%	87.0%	86.0%	92.6%	84.8%	89.2%	86.0%
II	Environment (Room/Safety)	83.4%	91.6%	81.6%	78.4%	85.4%	86.2%	97.0%	85.8%	91.2%	86.8%
III	Dietary	85.4%	93.2%	81.4%	77.0%	85.8%	85.0%	100.0%	87.4%	93.6%	87.6%
IV	Patient Care	89.2%	88.4%	78.8%	83.0%	86.4%	87.8%	97.8%	85.6%	93.0%	87.8%
V	Laboratory	86.2%	90.6%	80.8%	88.0%	86.4%	86.4%	100.0%	89.4%	94.6%	89.2%
VI	Radiology	88.4%	93.8%	87.0%	90.0%	88.6%	88.0%	100.0%	93.8%	94.6%	91.6%
VII	Family / Visitors	89.2%	89.2%	78.2%	87.0%	86.4%	88.0%	100.0%	90.0%	93.2%	89.0%
VIII	Physician	86.8%	89.2%	76.2%	82.6%	88.6%	87.0%	95.0%	89.2%	94.0%	87.6%
IX	Patient Discharge	86.6%	91.0%	74.6%	80.0%	88.4%	89.4%	97.6%	91.2%	92.6%	88.0%
X	Team Work / Attitude	85.2%	89.4%	81.6%	86.0%	87.2%	91.0%	92.6%	91.2%	94.2%	88.8%
XII	Overall Satisfaction (Recommend/Reuse)	80.6%	86.4%	80.0%	78.8%	92.4%	90.0%	85.0%	86.6%	97.8%	86.4%

Rationale: Texas RHP 1's community needs assessment (CN.6) found a significant need for improvement in efficiency and effectiveness of healthcare delivery. Red River Regional Hospital offers a full continuum of healthcare services to the Fannin County community and strives to constantly improve overall patient satisfaction scores.

The real challenge for RRRH is to identify pockets of innovation in the hospital that are dramatically improving quality, cost, and satisfaction. A recent article suggests that one way to improve cost, quality and satisfaction is to develop more rigorous discharge processes, especially in the area of medication reconciliation and patient education. Dr. Clancy's article and other research also cite myriad programmatic interventions from around the country that aim to improve quality, cost, and satisfaction.

(Clancy, "Reengineering the Hospital Discharge Process: A protocol to improve patient safety, reduce cost and boost patient satisfaction." American Journal of Medical Quality, July/August 2009 vol 24, no. 344-346.)

Related Category 3 Outcome Measures: The goal of implementing the patient care experience project (177870603.2.1) is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, RRRH is targeting long term improvement in HCAHPS scores through the implementation of a facility wide, transformative program. The primary outcome measure that will demonstrate our success toward that goal is to increase the facility's "overall" HCAHPS score by 10% over baseline as measured by an objective outsource vendor.

Relationship to Other Projects: The RRRH clinic will begin offering extended hours and additional physician staffing (177870603.1.1) to provide expanded access to primary care and preventive services. The expansion of access to primary care providers will help patients manage chronic disease and improve patient health outcomes. The expansion of primary care

access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (177870603.3.1) due to enhanced physician-patient relationships, preventive care, and chronic disease management.

Providing primary care to more patients through our extended hours and staffing will allow RRRH to make a significant impact in disease management. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2) and decrease the cost of acute inpatient care.

The structured outpatient program (SOP) for geriatric, behavioral health patients will improve the functional status of individuals receiving specialized interventions (177870603.2.3). Providing this outpatient program for geriatric, behavioral health patients will effectively decrease the 30 day readmission rate for the same population (177870603.3.4).

While clinic hours, staffing, and behavioral therapy reduce preventable admissions, redesigning to improve the patient experience (177870603.2.2) will improve overall patient satisfaction for inpatient admissions that could not be prevented. We will increase patient satisfaction scores (177870603.3.3) by implementing a mix of administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: RRRH has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: RRRH plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: RRRH's implementation of a rigorous patient satisfaction improvement program is expected to have a measureable impact on patient safety, quality, and cost. As described in the matrix below, the best aggregate measure of these items will be improvement in percentile ranking of overall patient satisfaction scores.

One specific impact of improved patient satisfaction is in the area of improving the hospital discharge process. Research in this area suggests that improved medication reconciliation, and post discharge follow-ups may have an impact on downstream re-admissions for certain target populations.

As shown in the table below, a 20% decrease in readmissions could mean a savings of as much as $303,000 per year. Accordingly, RRRH's average DSRIP funding request of approximately

$289,000 per year (Category 2 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings from Patient Experience Improvement	
Annual Discharges	879
Avg Readmissions %*	18%
Readmissions	158
Cost per Readmission*	$ 9,600
Cost of Readmissions	**$ 1,518,912**
% Decrease in Readmissions	20%
Prevented Readmissions	32
Estimated Annual Savings	**$ 303,782**

* AHRQ

177870603.2.2	***2.4.1***	***2.4.1.A-D***	***IMPROVE PATIENT CARE EXPERIENCE***
Red River Regional Hospital			***177870603***
Related Category 3 Outcome Measure(s):	***177870603.3.3***	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores.*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.4.1.P-2 Write and disseminate a patient/family experience strategic plan. **Metric: 2.4.1.P-2.1** Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization **Baseline/Goal:** Submit the plan. **Data Source**: Documentation **Milestone 1 Estimated Incentive Payment:** $221,181	**Milestone 2: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Establish baseline as overall percentile ranking compared to comparably sized hospitals. It is anticipated that RRRH's baseline is below the 40th %ile. **Data Source**: As reported by Press Ganey or similar company. **Milestone 2 Estimated Incentive Payment:** $246,838	**Milestone 3: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Achieve 55th %ile **Data Source**: As reported by Press Ganey or similar company. **Milestone 3 Estimated Incentive Payment:** $252,206	**Milestone 4: 2.4.1.I-16** Improve patient satisfaction/experience scores. **Metric: 2.4.1.I-16.1** Percent improvement of patient satisfaction scores for a specific tool over baseline. **Baseline/Goal:** Achieve 60th%ile. **Data Source**: As reported by Press Ganey or similar company. **Milestone 4 Estimated Incentive Payment:** $209,838
Year 2 Estimated Total DSRIP: $221,181	Year 3 Estimated Total DSRIP: $246,838	Year 4 Estimated Total DSRIP: $252,206	Year 5 Estimated Total DSRIP: $209,838
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$930,062***			

Project Option: 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards geriatric, behavioral health patients
Unique Project ID Number: 177870603.2.3 (Pass 3)
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Project Abstract

Provider Description: Red River Regional Hospital (RRRH) is a 25-bed critical access hospital that provides inpatient, outpatient, and emergency services to its communities. RRRH's primary service area is Fannin County, but the secondary service area extends to surrounding communities. The service area population is estimated at around 33,915.

Intervention: Red River Regional Hospital will provide a structured outpatient program (SOP) for geriatric, behavioral health patients. This outpatient therapy program will provide needed behavioral health services to the growing geriatric population.

Need for the Project: In the current environment of tighter budgets and funding cuts, RRRH has been crippled with the lack of resources to provide needed care in the community. With the aging population and a lack of behavioral health services, the need for geriatric, behavioral health services will continue to grow. This project also meets at least two of the Northeast Texas community needs: insufficient access to behavioral care services (CN.2) and high costs due to potentially preventable hospitalizations (CN.4).

Target Population: The target population is service area geriatric, behavioral health patients in need of access to behavioral outpatient therapy. We anticipate serving an average of 55 patients per year with a Medicaid and indigent population of at least 15%.

Category 1 or 2 Expected Patient Benefits: The structured outpatient program for 60 geriatric, behavioral health patients to receive specialized interventions who demonstrate improved functional status on standardized instruments by DY 5. Patients will benefit from increased access to behavioral health services.

Category 3 Outcomes: Establishing a structured outpatient program (SOP) for geriatric, behavioral health patients (177870603.2.3) will decrease 30 day readmissions for behavioral health/substance abuse patients (177870603.3.4). RRRH plans to decrease 30 day readmissions for geriatric patients receiving interventions through structured outpatient therapy by 2.5% and 5% in demonstration years 4 and 5, respectively.

Project Narrative

Project Description: Red River Regional Hospital will provide a structured outpatient program (SOP) for geriatric, behavioral health patients. Specifically, our DY 5 goal is to see a 10% increase in individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments.

SOP services are highly structured, coordinated, multi-disciplinary treatment programs provided in a hospital-based outpatient setting. Patients usually receive treatment for up to five (5) days a week for between two (2) to three (3) hours during each therapeutic day of service. SOP services are physician-directed and based on an individualized treatment program developed for the patient following a comprehensive assessment and treatment planning process. The treatment modalities used in SOPs include group process therapy, individual and family therapy, medication management, and other related psychiatric treatment modalities. SOP services are part of a continuum that include Partial Hospitalization Program services, which are more intense than SOP services and Intensive Outpatient Program services, which are less intense than SOP services. Intensive Outpatient Program services are also physician-directed with patients receiving treatment for between two (2) and three (3) hours per day for up to three (3) days per week. Services can be oriented to the treatment needs of both psychiatric and chemical dependency patients.

Consistent with the overarching goal and vision of RHP 1, RRRH is moving toward a realization of the triple aim to improve the patient experience of care (including quality and satisfaction), improve the health of populations, and reduce the per capita cost of health care. In addition, addressing gaps in access to care is a key focus of RRRH. Northeast Texas is an area where patients face many challenges in accessing primary, specialty, and behavioral health care. Northeast Texas is older, poorer, and less educated than the state average. As a result, over half of counties in Region 1 are in the bottom quartile of Texas counties in health outcomes.

In order to meet the healthcare needs of our population within Northeast Texas, RRRH is proposing to establish outpatient geriatric, behavioral health services in order to decrease the need for more costly, future inpatient services. Expanding behavioral health care access with outpatient therapy services meets several community needs outlined by RHP 1, including: insufficient access to behavioral care services (CN.2), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

RRRH will design community-based specialized interventions for behavioral health patients needing outpatient therapy, including:

- Specialized behavioral therapies (cognitive and dialectical)
- Prescription medications

From an implementation perspective, RRRH will engage in the following specific tasks in the development of a robust Structured Outpatient Program (SOP). Though the specifics of the program will be developed in DY2, examples of specific means by which the project core components will be implemented could include:

- Task 1: Exploration and program design: RRRH seeks to employ an evidence based approach to the development of the SOP. Accordingly the project will initiate with an in depth review of related literature in order to understand what types of interventions

have had impactful results for similar target populations. Based on the results of that literature review, RRRH will convene a series of meetings with the appropriate constituent representatives to develop protocols for specific programmatic interventions that will achieve the intended outcomes.

- Task 2: Resource utilization and development: Once exploration and programmatic design are complete RRRH's team will work to develop and deploy a resource plan that will ensure that staffing is both adequate and competent to effectively implement the SOP. During this stage of the process, RRRH's team will also seek to identify in greater detail a list of potential patients who would benefit from participation in the SOP. Initially, these patients would be mined using RRRH's own clinical information systems, but broader targeting beyond RRRH patients is also expected. Finally, it is during this stage that program staff will be trained and specific space identified for program use.

- Task 3: Program implementation After planning stages are complete, RRRH will endeavor to implement the program. In turning planning into action, it may become necessary to adjust program components in order to ensure effective implementation.

Task 4: Program review and monitoring: Lastly, RRRH seeks to rigorously review the effectiveness of the program. It is RRRH's intent to "assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); participant surveys; provider surveys" and other means.

It is also important to note that RRRH seeks to engage outside consultative support in the development of the structured outpatient program (SOP). Several candidate firms with national expertise have been identified and will be selected upon preliminary DSRIP approval.

To reemphasize, using the methodology described above it is RRRH's intention to develop a and SOP program that meets all of the required project components including: assess size, characteristics and needs of target population; review literature with populations similar to target population to determine community based interventions that are effective in averting negative outcomes; develop project evaluation plan using qualitative and quantitative metrics to determine outcomes; design models which include an appropriate range of community based services and residential supports; and assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. These project components will be considered to increase the individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments by 10% in DY 5.

Starting Point/Baseline: RRRH has conducted a preliminary gap analysis to identify the need for geriatric, behavioral health services. The most effective way to provide these services is by utilizing outpatient therapy, in order to reduce unnecessary inpatient admissions (both acute care and behavioral institutions). Since this is a new initiative for RRRH, there is currently no baseline data for outpatient services provided to geriatric, behavioral health patients. As part of the project plan, we will collect baseline data in DY 3, but anticipate that the initial baseline will be 50 patients.

Rationale: Evidence based, outpatient therapies will be utilized to assist geriatric patients in the community to improve cognitive and dialectical abilities. It will assist in helping them to maintain a level of functioning in the community that allows them independence on an outpatient basis rather than inpatient basis. In addition to meeting community needs for behavioral health services and potentially preventable admissions (CN.2 and CN.4), the end result will be improved overall global functioning and a decrease in symptoms.

Research indicates that evidence based therapies are effective tools in preventing psychiatric hospital admissions and re-admissions. Adding outpatient therapy will give us the opportunity to impact the lives of persons with disabilities in a positive way. It could provide the emotional support and coping skills needed to decrease admissions to the hospital. It would improve stabilization and assist in maintaining a high level of functioning on an outpatient basis. Providing outpatient behavioral services will also prevent service area residents from traveling for their needs.

Related Category 3 Outcome Measures: Establishing a structured outpatient program (SOP) for geriatric, behavioral health patients (177870603.2.3) will decrease 30 day readmissions for behavioral health/substance abuse patients (177870603.3.4). RRRH plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the 30 day readmission rate. RRRH plans to decrease 30 day readmissions for geriatric patients receiving interventions through structured outpatient therapy by 2.5% and 5% in demonstration years 4 and 5, respectively.

The previously stated project description and rationale further describes how behavioral health outpatient therapy services will reduce 30 day readmissions for geriatric, behavioral health/substance abuse patients.

Relationship to Other Projects: The RRRH clinic will begin offering extended hours and additional physician staffing (177870603.1.1) to provide expanded access to primary care and preventive services. The expansion of access to primary care providers will help patients manage chronic disease and improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (177870603.3.1) due to enhanced physician-patient relationships, preventive care, and chronic disease management.

Providing primary care to more patients through our extended hours and staffing will allow RRRH to make a significant impact in disease management. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2) and decrease the cost of acute inpatient care.

The structured outpatient program (SOP) for geriatric, behavioral health patients will improve the functional status of individuals receiving specialized interventions (177870603.2.3). Providing this outpatient program for geriatric, behavioral health patients will effectively decrease the 30 day readmission rate for the same population (177870603.3.4).

While clinic hours, staffing, and behavioral therapy reduce preventable admissions, redesigning to improve the patient experience (177870603.2.2) will improve overall patient satisfaction for inpatient admissions that could not be prevented. We will increase patient satisfaction scores (177870603.3.3) by implementing a mix of administrative rounding and discharge planning programs.

Relationships to Other Performing Provider Projects in the RHP: RRRH has ensured that all project plans meet fulfill the community needs and operate in conjunction with the RHP-wide initiatives. Our proposed projects meet the needs of specific populations and will not duplicate services of other performing provider projects in the RHP. Furthermore, we will participate in a learning collaborative to support this project and share best practices, new ideas, and solutions with similar projects across the RHP.

Plan for Learning Collaborative: RRRH plans to participate in RHP-wide learning collaboratives with other providers with similar primary care access projects. Engaging in learning collaboratives will promote sharing challenges and best practices, and testing new ideas and solutions between providers implementing similar projects.

Project Valuation: The cost per inpatient psychiatric bed per day is approximately $685, compared to one therapy session hour at $75. At 50 hours per patient, we project that our program will serve 50 geriatric patients per year. Providing therapy for 50 patients rather than inpatient utilization will save approximately $155,000 per year in future institutionalization costs.

Accordingly, RRRH's average DSRIP funding request of approximately $50,000 per year (including Category 2 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Annual Savings Geriatric, Behavioral Health Outpatient Therapy		
Geriatric population served		50
Therapy Hours per Year	@ 50 per client	2,500
Therapy Cost per Session		$ 75
Therapy Cost per Year		**187,500**
New population served		50
Inpatient Bed Utilization per Year	ALOS @ 10 days	10
Cost per Inpatient Psych day*		$ 685
Inpatient Bed Cost per Year		**$ 342,505**
Estimated Annual Savings		**$ 155,005**

*CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011

177870603.2.3	***2.13.1***	***2.13.1.A-E***	**Interventions tailored towards geriatric, behavioral health patients**
Red River Regional Hospital			***177870603***
Related Category 3 Outcome Measure(s):	***177870603.3.4***	*3.IT-3.8*	*Behavioral Health /Substance Abuse 30 day readmission rate*
Year 2	Year 3	Year 4	Year 5
Milestone 1: 2.13.1.P-2 Design community-based specialized interventions for behavioral health patients needing outpatient therapy, including: • Specialized behavioral therapies • Prescription medications **Metric: 2.13.1.P-2.1** Project plans which are based on evidence / experience and which address the project goals **Baseline/Goal:** Project Documentation **Data Source**: Project plans and documentation **Milestone 1 Est Incentive Payment:** $34,340	**Milestone 2: 2.13.1.I-5** Functional Status **Metric: 2.13.1.I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** Determine baseline percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. We anticipate that the initial baseline will be approximately 50 patients. **Data Source:** Standardized functional assessment instruments (e.g. ANSA, CANS, etc.) **Milestone 2 Estimated Incentive Payment:** $38,323	**Milestone 3: 2.13.1.I-5** Functional Status **Metric 2: 2.13.1.I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 10% increase (5) individuals receiving specialized interventions over a baseline of 50 who demonstrate improved functional status on standardized instruments. **Data Source:** Standardized functional assessment instruments (e.g. ANSA, CANS, etc.) **Milestone 3 Estimated Incentive Payment:** $ 39,157	**Milestone 4: 2.13.1.I-5** Functional Status **Metric 2: 2.13.1.I-5.1** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (ANSA, CANS, etc.) Numerator: The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Denominator: The number of individuals receiving specialized interventions. **Baseline/Goal:** 20% increase (10) individuals receiving specialized interventions over a baseline of 50 who demonstrate improved functional status on standardized instruments. **Data Source:** Standardized functional assessment instruments (e.g. ANSA, CANS, etc.) **Milestone 4 Estimated Incentive Payment:** $ 32,579
Year 2 Estimated Total DSRIP Funding: $34,340	Year 3 Estimated Total DSRIP Funding: $38,323	Year 4 Estimated Total DSRIP Funding: $39,157	Year 5 Estimated Total DSRIP Funding: $32,579
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$144,399***			

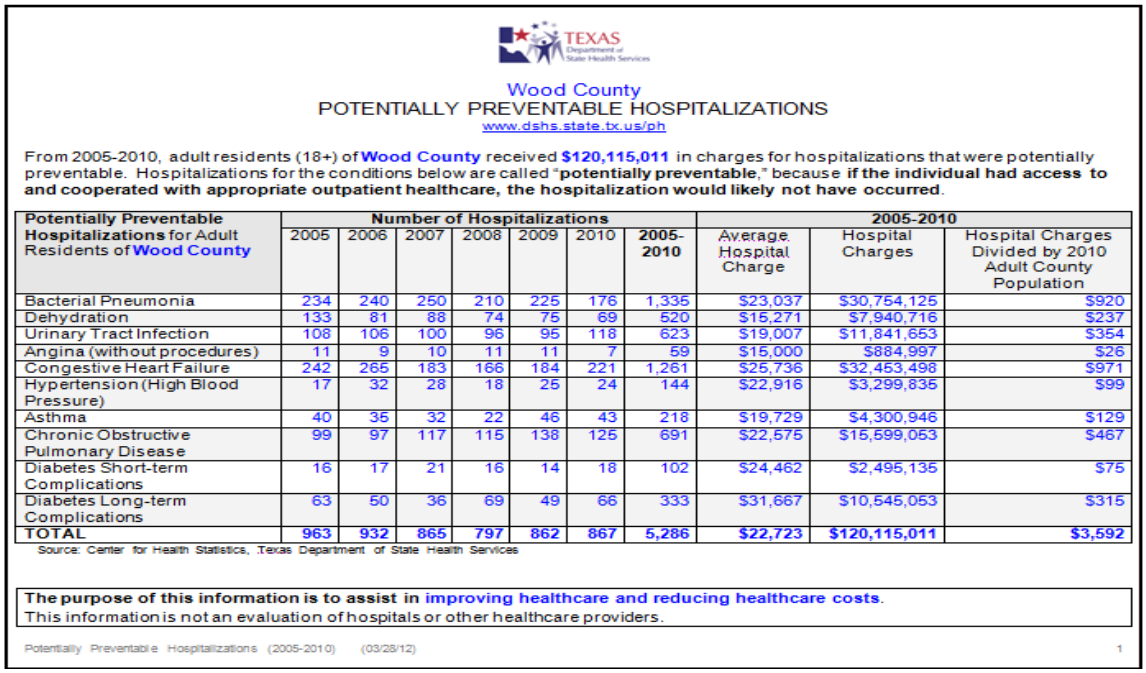
E. Category 3: Quality Improvements

The goal of Category 3 is to assess an outcome of a project implemented under Category 1 or 2. As described in the Program Funding and Mechanics Protocol, each Category 1 and 2 project is required to have an associated Category 3 outcome measure.

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 017624002.3.1
Performing Provider & TPI: ETMC Quitman 017624002

Outcome Measure Description: ETMC Quitman's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Wood County alone there were approximately 5,286 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $120M in charges.



TEXAS Department of State Health Services

Wood County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Wood County** received **$120,115,011** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Wood County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	234	240	250	210	225	176	1,335	$23,037	$30,754,125	$920
Dehydration	133	81	88	74	75	69	520	$15,271	$7,940,716	$237
Urinary Tract Infection	108	106	100	96	95	118	623	$19,007	$11,841,653	$354
Angina (without procedures)	11	9	10	11	11	7	59	$15,000	$884,997	$26
Congestive Heart Failure	242	265	183	166	184	221	1,261	$25,736	$32,453,498	$971
Hypertension (High Blood Pressure)	17	32	28	18	25	24	144	$22,916	$3,299,835	$99
Asthma	40	35	32	22	46	43	218	$19,729	$4,300,946	$129
Chronic Obstructive Pulmonary Disease	99	97	117	115	138	125	691	$22,575	$15,599,053	$467
Diabetes Short-term Complications	16	17	21	16	14	18	102	$24,462	$2,495,135	$75
Diabetes Long-term Complications	63	50	36	69	49	66	333	$31,667	$10,545,053	$315
TOTAL	**963**	**932**	**865**	**797**	**862**	**867**	**5,286**	**$22,723**	**$120,115,011**	**$3,592**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

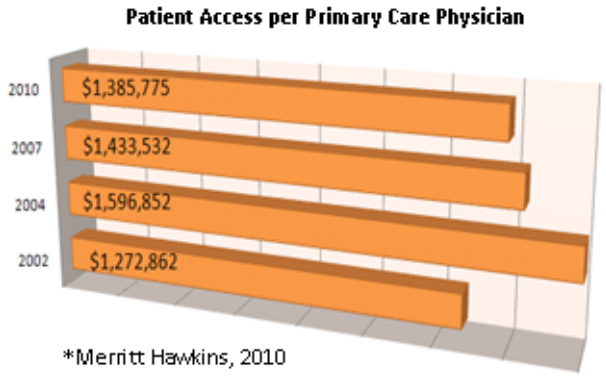
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15%

decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $696,129 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $640,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Primary Care Capacity		
Total New Clinic Patients		2,467
ED visits / year / person		0.45
Potential ED Visits		1,113
ED Visits Reduced @ 15%		167
Avg ED Payment		$425
ED Savings	**$**	**70,932**
IP Admissions / year / person		0.11
Potential IP Admissions		281
Admissions Reduced @ 18%		51
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**625,197**
Total Estimated Savings	**$**	**696,129**



017624002.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Quitman			***017624002***
Related Category 1 or 2 Projects:	***017624002.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $59,270	**Process Milestone 2 Estimated Incentive Payment:** $68,702	**Outcome Improvement Target 1 Estimated Incentive Payment:** $110,243	**Outcome Improvement Target 2 Estimated Incentive Payment:** $263,625
Year 2 Estimated Total DSRIP Funding: $59,270	Year 3 Estimated Total DSRIP Funding: $68,702	Year 4 Estimated Total DSRIP Funding: $110,243	Year 5 Estimated Total DSRIP Funding: $263,625
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$501,840***			

Outcome Measure (Improvement Target): IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) - NQF 0059*
Unique RHP Outcome Identification Number: 020812601.3.1
Performing Provider & TPI: ETMC Tyler 020812601

Outcome Measure Description: Through expanded diabetes management access, our new endocrinologist (020812601.1.1) will decrease the percentage of his/her clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

ETMC Tyler plans to engage in project planning for decreasing HbA1c poor control (>9.0%) patients in the new endocrinology clinic during DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for the percentage of HbA1c poor control (>9.0%) patients. ETMC plans to decrease the percentage of HbA1c poor control (>9.0%) patients —ETMC endocrinology clinic patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Rationale: Controlling hemoglobin A1c in diabetic patients is one of the leading indicators for effective diabetes management, and managing the disease is needed to improve health status and decrease cost. Diabetes is a disease that has reached epidemic proportions across the US and Texas. According to the Kaiser Family Foundation, 9.8% of adults in Texas have been diagnosed with diabetes while 6.2% of all US adults have diabetes. According to the Centers for Disease Control (CDC) in Atlanta, diabetes was the sixth leading cause of death on U.S. death certificates in 2006. Overall, the risk for death among people with diabetes is about twice that of people without diabetes of similar age. Diabetes is also the leading cause of new cases of blindness, kidney failure, and non-traumatic lower-extremity amputations among adults.

Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

If current trends continue, 1 in 3 Americans will develop diabetes sometime in their lifetime, and those with diabetes will lose an average of 10-15 years of life. African American, Hispanic, American Indian, and Alaska Native adults are twice as likely as white adults to have diabetes. Therefore, the large Hispanic population is at risk throughout the East Texas communities. The diabetes epidemic is only getting worse, so the recruitment of an endocrinologist and diabetes management is essential to serving the health needs of East Texas.

Outcome Measure Valuation: In a 2010 diabetes disease management study by The American Journal of Managed Care, the intervention group decreased their all-cause total medical costs by $984.87 per member per year (PMPY). They study's conclusion stated that "a disease

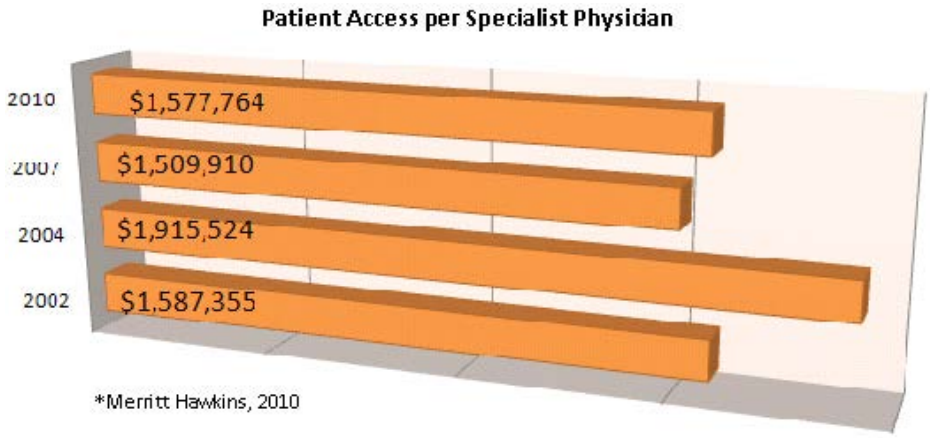
management program for high-risk patients with diabetes and CAD was effective in reducing hospital inpatient admission and total costs in a Medicare Advantage population."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a specialist physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional specialist.

The charts below value diabetes management at $1.9M per year and access from a specialist at $1.5M. Accordingly, ETMC's average DSRIP funding request of approximately $1.2M per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

Estimated Savings from Diabetes Management	
Clinic visits per Year	2,000
Annual Savings per Diabetic patient*	$ 984.87
Estimated Annual Savings	**$ 1,969,740**

*American Journal of Managed Care



(Rosenzweig, et. al. Diabetes Disease Management in Medicare Advantage Reduces Hospitalizations and Costs. *The American Journal of Managed Care.* 2010;16(7):e157-e162)

020812601.3.1	***3.IT-1.10***	**Diabetes care: *HbA1c poor control (>9.0%)***	
ETMC Tyler			***020812601***
Related Category 1 or 2 Projects:	***020812601.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Numerator**:** Number of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator**:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Metric:** Documentation of baseline percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. **Data Source:** EHR, Registry, Claims, Administrative clinical data	**Outcome Improvement Target 1: IT-1.10** Decrease percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Numerator**:** Number of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator**:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Improvement Target:** 4% decrease in percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Calculated as (new # -baseline) /baseline **Data Source:** EHR, Registry, Claims, Administrative clinical data	**Outcome Improvement Target 2: IT-1.10** Decrease percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Numerator**:** Number of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator**:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Improvement Target:** 8% decrease in percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Calculated as (new # -baseline) /baseline **Data Source:** EHR, Registry, Claims, Administrative clinical data
Process Milestone 1 Estimated Incentive Payment: $ 109,420	**Process Milestone 2 Estimated Incentive Payment:** $ 126,832	**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 203,521	**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 486,681
Year 2 Estimated Total DSRIP Funding: $109,420	Year 3 Estimated Total DSRIP Funding: $126,832	Year 4 Estimated Total DSRIP Funding: $203,521	Year 5 Estimated Total DSRIP Funding: $486,681
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$926,454***			

Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 Day Re-admission Rate
Unique RHP Outcome Identification Number: 020812601.3.2
Performing Provider & TPI: ETMC Tyler 020812601

Outcome Measure Description: The goal of recruiting cardiologist for regional coverage (1.9.2) is to be able to increase the supply of specialty services in several targeted and underserved rural markets while decreasing the 30 day readmission rate. More specifically, ETMC has targeted long term management of cardiology patients as in these rural markets in order to provide care close to home and ultimately avoid costly readmission down the road.

ETMC proposes to contract with a Tyler based cardiology group to offer regular periodic (i.e. one day per week or similar) cardiology clinics at 5 rural locations that are adjacent to ETMC's rural hospitals. In addition these rural hospitals will provide diagnostic testing infrastructure and capability to ensure that a higher level of a care is provided close to home for these patients.

The primary outcome measure that will demonstrate our success toward that goal is to decrease the 30 day re-admission rate by 8% in DY5 for patients in targeted rural markets.

Rationale: Historically, smaller rural markets in ETMC's service area have had an extremely difficult time recruiting and retaining specialists, especially in the areas of cardiology. From time to time, larger Tyler based cardiology groups have offered some clinics in those areas, but coverage has been inconsistent. Moreover, most if not all of the diagnostic testing has been done in physician offices in Tyler, thus requiring cardiology patients to drive long distances to receive care, thus leading to underutilization of preventative care and repeated readmissions. Moreover, as sited in the community needs assessment (CN.1), more appointment availability will allow patients to come at their convenience and have better access to specialty care. In a recent article, Rumsfeld et al have argued that while the reasons for hospital readmission are a "complex, multi-factorial outcome measure, and it remains unclear how hospital readmission rates can effectively and safely be lowered." They go on to suggest that "the answer lies in improving institutional quality of care."

(John S. Rumsfeld, MD, PhD; Larry A. Allen, MD, MHS, "Reducing Cardiac Readmission Rates, Does Coronary Artery Bypass Graft Surgery Provide Clarity" J Am Coll Cardiol Intv. 2011;4(5):577-578. doi:10.1016/j.jcin.2011.04.002)

Moreover, the relationship between hospital readmission rates and quality of care is well-documented and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates.

As shown in the chart below, The Texas Department of State Health Services suggests that in Smith County alone there were approximately 14,769 potentially preventable hospitalizations

from 2005 -2010. These patients represented more than $483M in charges. Of those patients, almost 42% had cardiology related diagnoses of angina, CHF, Hypertension or COPD. It is estimated that an equal number of patients could be impacted in the surrounding counties.

TEXAS Department of State Health Services

Smith County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
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From 2005-2010, adult residents (18+) of **Smith County** received **$483,278,977** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of Smith County	Number of Hospitalizations						2005-2010			
	2005	2006	2007	2008	2009	2010	2005-2010	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	535	505	548	478	515	567	3,148	$35,714	$112,429,028	$721
Dehydration	170	190	180	187	170	125	1,022	$21,791	$22,270,044	$143
Urinary Tract Infection	268	320	272	316	336	364	1,876	$27,033	$50,714,370	$325
Angina (without procedures)	31	28	37	33	25	22	176	$23,747	$4,179,398	$27
Congestive Heart Failure	700	690	629	628	599	636	3,882	$34,767	$134,966,405	$866
Hypertension (High Blood Pressure)	79	102	101	96	158	146	682	$26,659	$18,181,713	$117
Asthma	107	110	107	97	114	96	631	$28,075	$17,715,244	$114
Chronic Obstructive Pulmonary Disease	212	212	215	249	272	282	1,442	$32,249	$46,502,694	$298
Diabetes Short-term Complications	107	128	121	141	108	100	705	$26,572	$18,733,608	$120
Diabetes Long-term Complications	187	196	173	187	234	228	1,205	$47,790	$57,586,473	$369
TOTAL	2,396	2,481	2,383	2,412	2,531	2,566	14,769	$32,723	$483,278,977	$3,100

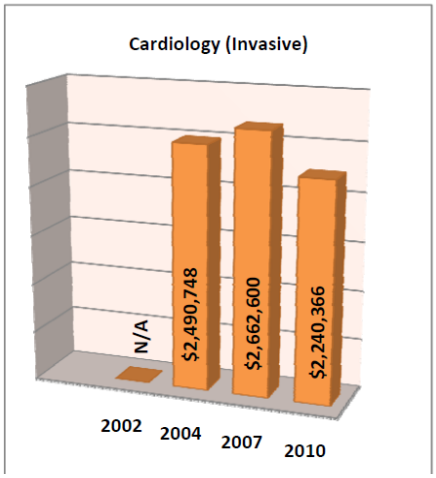
Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a cardiologist on behalf of his/her affiliated hospital.

The study suggests a value of $2.2M per year. Accordingly, ETMCRHS's average DSRIP funding request of $1.8M per year is targeted to be less than the value of cardiology access expansion so that the Medicare program accrues a net benefit.



020812601.3.2	***3.IT-3.2***	**CHF 30 Day Re-Admission Rate**	
ETMC Tyler			***020812601***
Related Category 1 or 2 Projects:	***020812601.1.2***		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1:P-2 Establish baseline rate for CHF readmission rates in the target areas. **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Metric:** Documentation of baseline metrics for project plans **Data Source**: EHR, Registry, Claims **Milestone 1 Estimated Incentive Payment:** $ 178,969	**Outcome Improvement Target 1: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 4% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 207,448	**Outcome Improvement Target 2: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 6% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 332,882	**Outcome Improvement Target 3: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 8% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 3 Estimated Incentive Payment:** $ 796,022
Year 2 Estimated Total DSRIP Funding (add each milestone): $ 178,969	Year 3 Estimated Total DSRIP Funding: $207,448	Year 4 Estimated Total DSRIP Funding: $332,882	Year 5 Estimated Total DSRIP Funding: $796,022
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,515,321***			

Outcome Measure (Improvement Target): IT-1.18 Follow-Up after Hospitalization for Mental Illness-NQF0576
Unique RHP Outcome Identification Number: 020812601.3.3
Performing Provider & TPI: ETMC Tyler 020812601

Outcome Measure Description: We propose to support access to behavioral health providers in the underserved area by recruiting a full-time psychiatrist for outpatient and partial hospitalization services. This outcome measure for the new psychiatrist assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

Rate 1 - The percentage of members who received follow-up within 30 days of discharge
Rate 2 - The percentage of members who received follow-up within 7 days of discharge

ETMC Tyler plans to engage in project planning in DY 2 to provide follow-up services after hospitalization for behavioral health patients by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for increasing follow-up after hospitalization for mental illness. ETMC plans to increase the number of patients who received follow-up within 30 days and 7 days of discharge by 4% and 8% in demonstration years 4 and 5, respectively.

Rationale: According to the Association for Ambulatory Behavioral Healthcare (AABH), partial hospitalization is the part of the mental health continuum that combines the best facets of inpatient care with the best of outpatient care. Partial hospitalization is an avenue of providing clinically equivalent mental healthcare at a much lower cost than inpatient treatment.

Expansion of behavioral health services is crucial for the national healthcare system to complete the entire continuum of care. The historic lack of providers and attention to mental health needs has created a serious shortage of behavioral health services. While ETMC has used its Behavioral Health Center to take the lead on behavioral services, there is still a significant shortage for outpatient and partial hospitalization services. With expanded behavioral health access, more patients will have the opportunity to treat episodes early, maintain follow up care, and prevent future inpatient utilization. Recruitment of a psychiatrist will be another step in providing better mental health access to an underserved population.

Outcome Measure Valuation: AABH studies have shown a direct savings of 40-60% over inpatient benefits. There are also indirect savings of partial hospitalization and outpatient services because an employee may be able to work on at least a limited basis, thus maintaining productivity. Furthermore, there is evidence that those who successfully complete partial hospitalization treatment generally will require less treatment in the future.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a psychiatrist on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional psychiatrist.

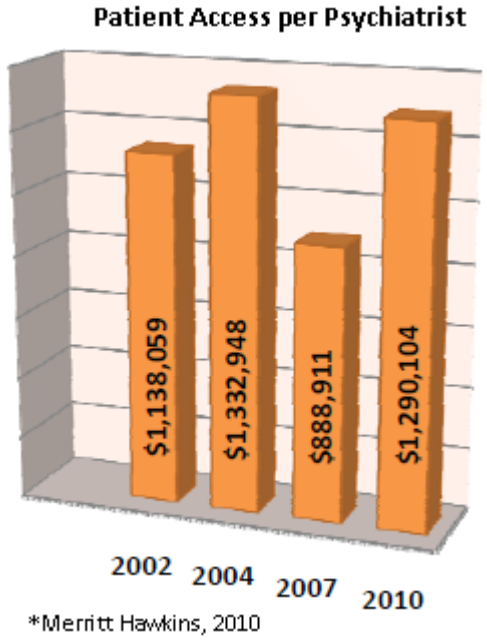
The charts below value outpatient and partial hospitalization services at $1.47M per year and access from a psychiatrist at $1.29M. Accordingly, ETMC's average DSRIP funding request of approximately $1M per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

Estimated Savings Expansion of Outpatient and Partial Hospitalization	
Estimated Patients Served	750
ED Visits per SMI patient[1]	0.84
ED Visits	630
Prevented ED Visits @ 60% Reduction	**378**
ED Cost per Psych Patient[2]	$ 2,264
ED Savings	**$ 855,792**
Inpatient Admissions per SMI patient[1]	0.20
Inpatient Admissions	150
Prevented Admissions @ 60% Reduction	**90**
Inpatient Psych ALOS	10
Cost per Inpatient Psych day[3]	$ 685
Inpatient Savings	**$ 616,509**
Total Estimated Savings	**$ 1,472,301**

1) *Emergency Medicine International*, 2012

2) CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011

3) National Alliance on Mental Illness



020812601.3.3	*3.IT-1.18*	**Follow-Up After Hospitalization for Mental Illness-NQF0576**	
ETMC Tyler			***020812601***
Related Category 1 or 2 Projects:	***020812601.1.3***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $ 93,648	**Process Milestone 2: P-2** Establish baseline % of patients receiving Follow-Up After Hospitalization for Mental Illness within **30 days AND 7 days** of discharge. Numerator**:** **Rate 1**: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within **30 days** after discharge. Include visits that occur on the date of discharge. **Rate 2**: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within **7 days** after discharge. Include visits that occur on the date of discharge. Denominator**:** Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting with a principal mental health diagnosis. The denominator for this measure is based on discharges. **Metric:** Documentation of baseline percentage of members who received follow-up within **30 days** of discharge. Documentation of baseline percentage of members who received follow-up within **7 days** of discharge. **Data Source:** EHR, Claims **Process Milestone 2 Estimated Incentive Payment:** $ 108,550	**Outcome Improvement Target 1: IT-1.18** Increase percentage of patients receiving Follow-Up After Hospitalization for Mental Illness within **30 days AND 7 days** of discharge. Numerator**:** **Rate 1**: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within **30 days** after discharge. Include visits that occur on the date of discharge. **Rate 2**: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within **7 days** after discharge. Include visits that occur on the date of discharge. Denominator**:** Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting with a principal mental health diagnosis. The denominator for this measure is based on discharges. **Improvement Target:** 4% increase in patients receiving Follow-Up After Hospitalization for Mental Illness within **30 days** of discharge. Calculated as (new # -baseline) /baseline 4% increase in patients receiving Follow-Up After Hospitalization for Mental Illness within **7 days** of discharge. Calculated as (new # -baseline) /baseline **Data Source:** EHR, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 174,185	**Outcome Improvement Target 2: IT-1.18** Increase percentage of patients receiving Follow-Up After Hospitalization for Mental Illness within **30 days AND 7 days** of discharge. Numerator**:** **Rate 1**: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within **30 days** after discharge. Include visits that occur on the date of discharge. **Rate 2**: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within **7 days** after discharge. Include visits that occur on the date of discharge. Denominator**:** Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting with a principal mental health diagnosis. The denominator for this measure is based on discharges. **Improvement Target:** 8% increase in patients receiving Follow-Up After Hospitalization for Mental Illness within **30 days** of discharge. Calculated as (new # -baseline) /baseline 8% increase in patients receiving Follow-Up After Hospitalization for Mental Illness within **7 days** of discharge. Calculated as (new # -baseline) /baseline **Data Source:** EHR, Claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 416,529

Year 2 Estimated Total DSRIP Funding: $93,648	Year 3 Estimated Total DSRIP Funding: $108,550	Year 4 Estimated Total DSRIP Funding: $174,185	Year 5 Estimated Total DSRIP Funding: $416,529
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$792,912***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 020812601.3.4
Performing Provider & TPI: ETMC Tyler 020812601

Outcome Measure Description: ETMC Tyler's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Smith County alone there were approximately 14,769 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $483M in charges.

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From 2005-2010, adult residents (18+) of **Smith County** received **$483,278,977** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of Smith County	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	2005-2010	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	535	505	548	478	515	567	3,148	$35,714	$112,429,028	$721
Dehydration	170	190	180	187	170	125	1,022	$21,791	$22,270,044	$143
Urinary Tract Infection	268	320	272	316	336	364	1,876	$27,033	$50,714,370	$325
Angina (without procedures)	31	28	37	33	25	22	176	$23,747	$4,179,398	$27
Congestive Heart Failure	700	690	629	628	599	636	3,882	$34,767	$134,966,405	$866
Hypertension (High Blood Pressure)	79	102	101	96	158	146	682	$26,659	$18,181,713	$117
Asthma	107	110	107	97	114	96	631	$28,075	$17,715,244	$114
Chronic Obstructive Pulmonary Disease	212	212	215	249	272	282	1,442	$32,249	$46,502,694	$298
Diabetes Short-term Complications	107	128	121	141	108	100	705	$26,572	$18,733,608	$120
Diabetes Long-term Complications	187	196	173	187	234	228	1,205	$47,790	$57,586,473	$369
TOTAL	2,396	2,481	2,383	2,412	2,531	2,566	14,769	$32,723	$483,278,977	$3,100

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $1.2M per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		43,951
% Clinic Appropriate		10%
Clinic Appropriate Patients		4,395
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**1,869,632**
Clinic Payment @ 78% savings	$	411,319
Total Estimated Savings	**$**	**1,458,313**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

020812601.3.4	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Tyler			***020812601***
Related Category 1 or 2 Projects:	***020812601.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $116,495	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $135,033	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $216,682	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $518,152
Year 2 Estimated Total DSRIP Funding: $116,495	Year 3 Estimated Total DSRIP Funding: $135,033	Year 4 Estimated Total DSRIP Funding: $216,682	Year 5 Estimated Total DSRIP Funding: $518,152
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$986,362***			

Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 Day Re-admission Rate
Unique RHP Outcome Identification Number: 020812601.3.5
Performing Provider & TPI: ETMC Tyler 020812601

Outcome Measure Description: The goal of implementing ETMC Tyler's care transitions project (2.12.1) is to reduce potentially preventable readmissions by implementing the re-engineered discharge (RED) design. Focusing on congestive heart failure (CHF) patients, the protocol will create smooth transitions of care from inpatient to outpatient settings by providing care management during this time period.

To create and implement discharge care protocols for CHF patients—much like the AHRQ designed protocol utilized in Project RED. The three core elements of Project RED are the assignment of discharge advocates, the development of a specific after-hospital care plan (AHCP), and follow-up phone calls to the patient's home. The primary outcome measure that will demonstrate our success toward that goal is to decrease the 30 day re-admission rate by 8% over baseline.

Rationale: According to AHRQ, almost one-third of CHF patients are readmitted within 30 days of discharge. A 2010 AHRQ study reports that the average cost of CHF readmission is $13,000 with Medicare expending $880 million annually. Although research suggests that guideline-based management of heart failure can prevent hospitalizations, AHRQ reports that many hospitals do not consistently follow these guidelines. Patients leave the hospital not understanding why they were admitted, what was done for them in the hospital, and how to care for themselves once released. In particular, patients often leave not knowing what medicines they should and should not be taking, what symptoms to look out for, and who to contact for problems. This lack of knowledge frequently causes patients to be readmitted, causing needless suffering and preventable health care costs.

The three core elements of a discharge advocate, the AHCP, and the follow-up phone call will provide patient-centered education, comprehensive discharge planning, and post-discharge reinforcement in a practical and easily applied method. Creating a coordinated transition from inpatient service to home will have multiple benefits to patient experience and safety. With timely and quick post-hospital stay follow-up, problems with understanding and deterioration in clinical health status can be quickly identified and addressed, in most cases over the phone. For patients who have been recently hospitalized, the lack of follow-up appointments and information regarding how to keep themselves healthy puts them at risk for readmission. Reducing expensive and unnecessary readmissions will free resources for care at more appropriate levels.

When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Patients cannot fully participate in their care during and after hospital stays without sufficient understanding of their diagnoses, medication, and self-care needs. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home and community-based services.

Outcome Measure Valuation: Creating a coordinated transition from inpatient service to home will have multiple benefits to patient experience and safety. With timely and quick post-hospital stay follow-up, problems with understanding and deterioration in clinical health status can be quickly identified and

addressed, in most cases over the phone. For patients who have been recently hospitalized, the lack of follow-up appointments and information regarding how to keep themselves healthy puts them at risk for readmission. Reducing expensive and unnecessary readmissions will free resources for care at more appropriate levels.

A trial study published by the *Annals of Internal Medicine* and the National Institutes of Health on the re-engineered hospital discharge program shows a significant reduction in readmissions and cost. The trial hospital realized a 34% lower total cost of care for the RED intervention group of patients. "The RED intervention [also] decreased hospital utilization (combined emergency department visits and readmissions) within 30 days of discharge by about 30%. More intervention group participants reported seeing their PCP for follow-up within 30 days and reported higher levels of preparedness for discharge. In addition, the intervention was successful in reducing hospital utilization among participants who frequently used hospital services." The estimated annual cost savings for CHF patients is shown below:

Estimated Savings from CHF Post-Discharge Support	
Annual Cardiac Admissions	1,772
% CHF Readmissions*	30%
CHF Readmissions	532
Cost per CHF Readmission*	$ 13,000
Cost of CHF Readmissions	**$ 6,910,800**
% Decrease in Readmissions	10%
Prevented Readmissions	53
Estimated Annual Savings	**$ 691,080**

* AHRQ

(Jack MD, Brian W., et al (2009). Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. *Annals of Internal Medicine*, 150(3), 178-187.)

020812601.3.5	*3.IT-3.2*	**CHF 30 Day Re-Admission Rate**	
ETMC Tyler			***020812601***
Related Category 1 or 2 Projects:	***020812601.2.2***		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1:P-2 Establish baseline rate for CHF readmission rates in the target areas. **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Metric:** Documentation of baseline metrics for project plans **Data Source**: EHR, Registry, Claims **Milestone 1 Estimated Incentive Payment:** $ 55,206	**Outcome Improvement Target 1: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 4% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 63,991	**Outcome Improvement Target 2: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 6% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 102,683	**Outcome Improvement Target 3: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 8% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 3 Estimated Incentive Payment:** $ 245,547
Year 2 Estimated Total DSRIP Funding (add each milestone): $ 55,206	Year 3 Estimated Total DSRIP Funding: $63,991	Year 4 Estimated Total DSRIP Funding: $102,683	Year 5 Estimated Total DSRIP Funding: $245,547
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$467,427***			

Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores.
Unique RHP Outcome Identification Number: 020812601.3.6
Performing Provider & TPI: ETMC Tyler 020812601

Outcome Measure Description: The goal of implementing the patient care experience project (020812601.2.3) is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, ETMCRHS is targeting long term improvement in HCAHPS scores through the implementation of a system wide, transformative program. The primary outcome measure that will demonstrate our success toward that goal is to increase the average of all facilities' "overall" HCAHPS score by 10% over baseline by DY 5 as measured by an objective outsource vendor (020812601.3.6).

Rationale: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

The real challenge for a regional system like ETMC is to identify pockets of innovation in the system that are dramatically improving quality, cost and satisfaction and transport those findings and processes around the system. A recent article suggests that one way to improve cost, quality and satisfaction is to develop more rigorous discharge processes, especially in the area of medication reconciliation and patient education. Dr. Clancy's article and other research also cite myriad programmatic interventions from around the country that aim to improve quality, cost and satisfaction.

Clancy, "Reengineering the Hospital Discharge Process: A protocol to improve patient safety, reduce cost and boost patient satisfaction." American Journal of Medical Quality, July/August 2009 vol 24, no. 344-346.

Outcome Measure Valuation: ETMC's implementation of a rigorous patient satisfaction improvement program is expected to have a measureable impact on patient safety, quality and cost. As described in the matrix below, the best aggregate measure of these items will be a system-wide improvement in percentile ranking of patient satisfaction scores at all facilities.
One specific impact of improved patient satisfaction is in the area of improving the hospital discharge process. Research in this area suggests that improved medication reconciliation, and post discharge follow-ups may have an impact on downstream re-admissions for certain target populations.

As shown in the table below, a modest 10% decrease in readmission rate for ETMC Tyler patients only (i.e. from 18% to 16.2%) could be mean a savings of as much as $3.45M to the CMS Program. Accordingly, ETMCRHS's average DSRIP funding request of $2.1M per year (Category 2 and 3) is targeted to be less than the savings of all ETMC facilities so that the CMS program accrues a net benefit.

Estimated Savings from Patient Experience Improvement	
Annual Discharges	20000
% Medicare Readmissions*	18%
Readmissions	3600
Medicare Cost per Readmission*	$ 9,600
Cost of Readmissions	**$ 34,560,000**
% Decrease in Readmissions	10%
Prevented Readmissions	360
Estimated Annual Savings	**$ 3,456,000**

* AHRQ

020812601.3.6	***3.IT-6.1***	**Percent improvement over baseline of patient satisfaction scores**	
ETMC Tyler			***020812601***
Related Category 1 or 2 Projects:	***022812601.2.3***		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $ 191,721	**Process Milestone 2: P-2** Establish baseline rate for ETMC's overall patient satisfaction. Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Metric:** Documentation of baseline top box (9-10) score for overall hospital rating domain **Data Source**: ETMC HCAHPS survey data as currently administered by Press Ganey and Associates. **Process Milestone 2 Estimated Incentive Payment:** $ 222,230	**Outcome Improvement Target 1: IT-6.1** Percent improvement over baseline of patient satisfaction scores Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Improvement Target:** 5% improvement over baseline of top box (9-10) score for overall hospital rating domain, calculated as (new # -baseline) /baseline **Data Source:** ETMC HCAHPS survey data as currently administered by Press Ganey and Associates. **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 356,601	**Outcome Improvement Target 2: IT-6.1** Percent improvement over baseline of patient satisfaction scores Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Improvement Target:** 10% improvement over baseline of top box (9-10) score for overall hospital rating domain, calculated as (new # -baseline) /baseline **Data Source:** ETMC HCAHPS survey data as currently administered by Press Ganey and Associates. **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 852,742
Year 2 Estimated Total DSRIP Funding (add each milestone): $191,721	Year 3 Estimated Total DSRIP Funding: $222,230	Year 4 Estimated Total DSRIP Funding: $356,601	Year 5 Estimated Total DSRIP Funding: $852,742
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,623,293***			

Outcome Measure (Improvement Target): IT-10.1 Quality of life
Unique RHP Outcome Identification Number: 084434201.3.1
Performing Provider & TPI: Texoma Community Center 084434201.3.1

Related Category 3 Outcome Measure(s): OD-10 Quality of Life/Functional Status

IT-10.1 Quality of life- (standalone measure)

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

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

Outcome Measure Description: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 and Category 2 process milestones selected for Project 084434201.1.1 are as follows: DY2 (1) procurement of necessary equipment and systems; DY 3 (2) establishing additional service sites, (3) implement training for staff; DY 4 (4) rewrite operational protocols and clinical guidelines to include additional types of patients, (5) [establish] individuals being served who have used telemedicine, telehealth, telementoring, and/or telemonitoring services for mental illness / substance use disorders, (6) participate in regional learning collaborative and implement "raise the floor" initiatives.

Outcome Improvement Targets by Year: The selected Improvement Milestones for Project 084434201.1.1 are as follows: DY 4 (7) Improve access to substance abuse treatment for individuals in underserved area that have used telemedicine, telehealth, and/or telemonitoring services; (8) Improve access to substance abuse treatment for individuals residing in the underserved area who have used telemedicine, telehealth, telementoring and/or telemonitoring services for treatment of mental illness / substance use disorders.

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity."(42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services, expanding provider network for substance abuse treatment, providing counseling options for those with no health insurance and expanding capacity through telementalhealth options as well as ensuring quality improvements across all projects will have an overall positive impact on patient functioning and result in a reduction of health costs across the regional area.

Therefore, the Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for Texoma Community Center to use to assess the impact of both individual projects and to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.3,CN.5)

Outcome Measure Valuation: "The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." (44) Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the "standalone" outcome indicator og Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of the projects. Using measured quality of life improvements to give definition to the size, scope, community benefit, efficiency and cost reduction/avoidance, beneficial outcomes can be quantified.

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

Based on the correlating Category 1 Project expectations, TCC can expect to intervene with approximately 163 individuals by expanding telemedicine services to additional patients in current and expanded programs, expanding telemedicine services to the intended substance abuse treatment program, anticipated Internship program and counseling services program as well as adding the primary care physician to current psychiatric services. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This valuation threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. (9a) Based on the valuation methodology selected, the correlated Category 1 Project is valued at $119,496.00 and based on allowable percentages, the Category 3 valuation is $26,654.00.

084434201.3.1	3.IT-10.1	Quality of Life (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Project:	084434201.1.1		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: [P-1] Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: No plan completed or documented Goal: Project Plan completed and ready for implementation Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,191.50 Process Milestone 2 [P-2]: Establish baseline number of individuals in underserved area using telemedicine/telehealth/ telemonitoring/ telementoring services P-2 Metric: AQoL Baseline established Baseline: No baseline number of individuals established Goal: AQoL Pre-Intervention Initial Scores established and being used for improvement guidelines Data Source: Plan and resource documentation, AQoL Pre-Intervention Initial Scores documentation Process Milestone 2 Estimated Incentive Payment: $ 1,191.50	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No development of data systems or results known Goal: Data systems developed, in place and results being assessed Data Source: Documentation of implementation, data collections and AQoL Surveys Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Process Milestone 3 Estimated Incentive Payment: $ 2,761.00 Outcome Improvement Target Milestone 4 [IT-10.1]: Quality of Life IT-1 Metric: Improved AQoL scores over baseline set in DY 2 Baseline: No AQoL improvement noted Goal: Improvement documented	Outcome Improvement Target Milestone 5 [IT-10.1]: Quality of Life IT-2 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 5 Estimated Incentive Payment*:* $ 5,908.00	Outcome Improvement Target Milestone 6 [IT-10.1]: Quality of Life IT-3 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 6 Estimated Incentive Payment*:* $ 12,842.00

084434201.3.1	3.IT-10.1	Quality of Life (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Project:	084434201.1.1		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Data Source: AQoL survey assessment results Outcome Improvement Target 4 Estimated Incentive Payment*:* $ 2,761.00		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 2,382.00	Year 3 Estimated Outcome Amount: $ 5,522.00	Year 4 Estimated Outcome Amount: $ 5,908.00	Year 5 Estimated Outcome Amount: $ 12,842.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 26,654.00			

Outcome Measure (Improvement Target): IT-10.1: Quality of Life
Unique RHP Outcome Identification Number: 084434201.3.2
Performing Provider & TPI: Texoma Community Center 084434201

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

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

Outcome Measure Description: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 process milestones selected for Project 084434201.1.2 are as follows: DY2 (1) identification and procurement of necessary equipment & licenses; and (2) develop protocols and clinical guidelines needed; DY 3 (3) hire and train certified and experienced licensed professionals for the program; (4) establish appropriate service sites and begin serving 5 new patients, (5) participate in regional learning collaborative; DY 4 (7) participate in regional learning collaborative; DY 5 (9) Participate in regional learning collaborative.

Outcome Improvement Targets by Year: The selected Improvement Milestones for Project 084434201.1.2 are as follows: DY 4 (6) increase utilization of substance abuse community behavioral health program by 10 patients over zero baseline and have 2 internships in place; DY 5 (8) increase utilization of substance abuse community behavioral health program by 15 patients over zero baseline and have 3 internships in place.

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements for Electronic Health Records implementation to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services as well as ensuring quality improvements across all projects will have an overall positive impact on their functioning in the community and result in a reduction of health costs across the regional area. The Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier to assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.5)

Outcome Measure Valuation: "The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." (44) Because the primary purpose of TCC is to improve the quality of life for all individuals it serves, with an emphasis on treatment that seeks functional improvements and advancements toward independence, it has selected the stand alone outcome indicator or Quality of Life/Functional Status as its Category 3 focus for determining initial success and overall value of its incentive projects.

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

utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. Two studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. (9e) Drummond et al, (2009) looked at alcohol treatment in a collaborative care setting, and QALYs increased by 0.0027. The average of these two values is 0.11135. (9f) Based on project expectations, TCC can expect to intervene with estimated 30 individuals for the region. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. Using the QALY methodology, the correlated Category 1 Project is valued at $166,746.00 by establishing 1 new treatment site and serving 30 new individuals. Using the allowable percentages, expected Category 3 valuation is $22,729.00.

Substance abuse services and the Internship program will focus TCC energies on increased individual and community value by expanding services to the “un-served” individual. The expanded services will evidence an increased value that will ultimately equate to improved quality of life for more people than have been traditionally served by TCC. As with all of TCC’s projects, focused attention will be given to serving people who are uninsured or have Medicaid.

084434201.3.2	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.1.2		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: [P-1] Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve AQoL scores for patients. Baseline: No plan completed or documented Goal: Project Plan completed and ready for implementation Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 995.50 Process Milestone 2 [P-2]: Establish baseline TBD P-2 Metric: AQoL Baseline established Baseline: No baseline number of individuals established Goal: AQoL Pre-Intervention Initial Scores established and being used for improvement guidelines Rationale: It is necessary to measure current performance to plan improvement. Process Milestone 2 Estimated Incentive Payment: $ 995.50	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No development of data systems or results known Goal: Data systems developed, in place and results being assessed Data Source: Documentation of implementation, data collections and AQoL Surveys Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Process Milestone 3 Estimated Incentive Payment: $ 2,308.00 Outcome Improvement Target Milestone 4 [IT-10.1]: Quality of Life IT-1 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results	Outcome Improvement Target Milestone 5 [IT-10.1]: Quality of Life IT-2 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 5 Estimated Incentive Payment*:* $ 4,937.00	Outcome Improvement Target Milestone 6 [IT-10.1]: Quality of Life IT-3 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 6 Estimated Incentive Payment*:* $ 10,734.00

084434201.3.2	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.1.2		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Outcome Improvement Target 4 Estimated Incentive Payment*:* $ 2,308.00		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 1,991.00	Year 3 Estimated Outcome Amount: $ 4,616.00	Year 4 Estimated Outcome Amount: $ 4,937.00	Year 5 Estimated Outcome Amount: $ 10,734.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 22,278.00			

Outcome Measure (Improvement Target): IT-10-1: Quality of Life
Unique RHP Outcome Identification Number: 084434201.3.3
Performing Provider & TPI: Texoma Community Center 084434201

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

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

Outcome Measure Description: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 process milestones selected for Project 084434201.1.3 are as follows: DY2 (1) Identification and procurement of necessary equipment & licenses to operate services; and (2) develop administrative protocols and clinical guidelines needed; DY 3 (3) hire and train 2 experienced licensed professionals for the program; (4) establish counseling services in 1 new community-based service site who are serving 10 patients over baseline; (5) participate in regional learning collaborative; DY 4 (7) participate in regional learning collaborative; DY 5 (9) Participate in regional learning collaborative.

Outcome Improvement Targets by Year: The selected Improvement Milestones for Project 084434201.1.3 are as follows: DY 4 (6) increase utilization of counseling community behavioral health program by 15 patients over baseline; DY 5 (8) increase utilization of counseling community behavioral health program by 25 patients over baseline.

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that procure the necessary equipment and service requirements, goals to improve efficiency and clinical data access, telemedicine expansion milestones to enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Implementation of these activities or services makes up the process milestones. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing additional substance abuse services, expanding provider network for substance abuse treatment, providing counseling options for those with no health insurance and expanding capacity through telementalhealth options as well as ensuring quality improvements across all projects will have an overall positive impact on their functioning in the community and result in a reduction of health costs across the regional area.

Therefore, the Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for this Local Mental Health Authority to use in assessing in impact of not only the individual projects, but to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.3,CN.5)

Outcome Measure Valuation: "The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." (44)

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

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

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. To support this methodology, the following studies were examined: Larimer et al. (2009) showed that this type of program for chronically homeless individuals with severe alcohol problems showed a cost-offset of $2,449 per month per individual. (9k) Then, Hollinghurst, et. al. (2010) examined online cognitive behavioral treatment (CBT) of depression and found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALy gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245. (9d) The calculated value of the correlated Category 1 Expand Behavioral Health Care Project was $ 265,192.00 and there is an expected patient impact of 50 individuals in RHP 1. The calculated related Category 3 valuation is $35,432.00.

The expanded behavioral health care through counseling project will focus TCC energies on increased individual and community value by expanding services to the “un-served” individual. The expanded services will evidence an increased value that will ultimately equate to improved quality of life for more people than have been traditionally served by TCC. As with all of TCC’s projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

084434201.3.3	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.1.3		
Starting Point/Baseline:	Baseline to be established in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: [P-1] Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: No plan completed or documented Goal: Project Plan completed and ready for implementation Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,583.00 Process Milestone 2 [P-2]: Establish baseline rates P-2 Metric: AQoL Baseline established Baseline: No baseline number of individuals established Goal: AQoL Pre-Intervention Initial Scores established and being used for improvement guidelines Process Milestone 2 Estimated Incentive Payment: $ 1,583.00	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No development of data systems or results known Goal: Data systems developed, in place and results being assessed Data Source: Documentation of implementation, data collections and AQoL Surveys Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Process Milestone 3 Estimated Incentive Payment: $ 3,670.50 Outcome Improvement Target Milestone 4 [IT-10.1]: Quality of Life Improvement Target: TBD IT-1 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline	Outcome Improvement Target Milestone 5 [IT-10.1]: Quality of Life IT-2 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 5 Estimated Incentive Payment*:* $ 7,853.00	Outcome Improvement Target Milestone 6 [IT-10.1]: Quality of Life IT-3 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 6 Estimated Incentive Payment*:* $ 17,072.00

084434201.3.3	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.1.3		
Starting Point/Baseline:	Baseline to be established in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Goal: Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 4 Estimated Incentive Payment*:* $ 3,670.50		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 3,166.00	Year 3 Estimated Outcome Amount: $ 7,341.00	Year 4 Estimated Outcome Amount: $ 7,853.00	Year 5 Estimated Outcome Amount: $ 17,072.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 35,432.00			

Outcome Measure (Improvement Target): IT-9.2: ED appropriate utilization.
Unique RHP Outcome Identification Number: 084434201.3.4
Performing Provider & TPI: Texoma Community Center 084434201

Outcome Measure Description: Reduce Emergency Department visits for target conditions:

- Behavioral Health/Substance Abuse

The process milestones selected to facilitate reporting outcomes for this Category Three Project will be as follows:

- P-1-- The Project Planning- engage stake holders, identify current capacity and needed resources.
- P-2—Establish baseline rates.
- P-3—Develop and test data systems.
- P-5—Disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome Measure Description: As capacity and resources are determined in Year 2, specific target reduction rates will then be determined and set. Based on past experience by TCC crisis staff, a reduction of emergency room visits will be experienced as additional patients are stabilized, both in the existing programs and in the newly planned substance abuse treatment facility and counseling center. Part of the project will be to track and document individuals with mental health, behavioral health, and substance abuse issues as presenting to emergency rooms for treatment, and reduce these ED visits over time. It is expected that TCC's projects (084434201.1.1, 084434201.1.2, 084434201.1.3 and 084434201.2.1) can, when facilitated, directly impact Category 3 Outcome Doman 9, and over time reduce costly emergency department visits for the targeted individuals. The selected Outcome Improvement Targets have not been determined for each year yet, since the baseline still needs to be established except that DY 2 is designated for Project Planning (engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans) and
DY 3 is designed for data collection and assessment. Each year does have an Improvement Target goal so that when the target percentages are determined, the outcome data can be tracked. It is expected to have positive outcomes across the region to reduce expensive emergency department use by individuals receiving the targeted interventions.

The Category 1 and Category 2 process milestones selected are designed to ensure effective implementation of each project regardless of the project scope. The process milestones are designed to ensure effective implementation of each project and the "Expand Quality Improvement Capacity" Project is specifically designed to enhance all other project's implementation success. The Process Milestone for DY 2 is: (1) Hire and train two quality improvement staff who will be trained in well-proven quality and efficiency improvement principles, tools and processes.

DY 3, DY 4 and DY 5 have the same Outcome Improvement measures with incrementing percentages (2) (3) and (4): Implement quality improvement data systems, collection, and reporting capabilities and increase QI reports by 10% over baseline of 12, then 15% over in DY 3, and 20% over in DY 4. Goals are in place to improve quality of care and collaboration of care with other providers in the region. TCC is poised to continue improvement trends into the next four years and beyond.
Rationale: This Outcome Domain was selected by TCC for our Quality Improvement Project since these are areas TCC treat and intend to expand treatment. The Quality Improvement Project will focus attention on the targeted Category 3 elements and, based on TCC's intervention experience, will lead to positive outcomes. At this point, baseline improvement targets ware not determined and will be established as the project roles out in DY2 and the baseline is established, along with evaluating capacity and resources. (CN.2, CN.3, CN.4, CN.5)

Project Valuation: "Seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer, according to a 2010 survey by the Schumacher Group, a Louisiana firm that manages emergency departments across the country. Ten percent said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER, increasing waiting times for all patients and overcrowding. The problem has worsened during the economic downturn. Since 2009, 32 states have cut their mental health budgets, largely from outpatient services that keep people healthy and out of the ER, according to a study by the National Alliance on Mental Illness, a patient advocacy group. And since 2010, states have closed or are planning to close nearly 4,000 state psychiatric beds, about 8 percent of capacity, according to the National Association of State Mental Health Program Directors Research Institute. " (39) Although the emergency room wait times are not as severe for hospitals in the TCC service area, emergency room care is costly and does not produce long-term results. Quality care means that providers are "… treating mental disorders as early as possible, holistically and close to the person's home and community lead to the best health outcomes."(40) Quality improvement for TCC will be focused on reducing emergency room visits, and readmissions, for persons with behavioral and or substance abuse problems. Substantial value will be created for individuals, and for the community at large, as TCC implements its projects and focuses its attention on delivering the right care at the right time. Interception of individuals inclined to seek care through hospital emergency rooms will result in reduced cost for an over-burdened medical system by creating more effective treatment options that result in stabilization of individuals with behavioral health and/or substance abuse issues because continuing community supports are "Very cost effective in the community when primary care is linked to a network of services." (41) To this end, the projects will collectively and progressively increase value by using an array of community-based services as the right care is delivered in the proper location.

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

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. Research supporting this valuation methodology includes Dewa, et. al. (2009) which found that collaborative care saved $503 per patient in disability benefits. (9h) A cost-utility analysis by Holtgrave, 2012 was based on data from the Housing and Health (H&H) Study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago and Los Angeles.(9b) They combined these outcome data with information on intervention costs to estimate the cost-QALY-saved by the HIV-related housing services is $62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby quality of life. Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. Utilizing the QALY methodology, with the research as backup, the related Category 1 Project's value will be $ 80,762.00 for

a minimum of 50 RHP 1 individuals potentially impacted and based on allowable percentages, the Outcome Measure valuation is $10,791.00.

As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

084434201.3.4	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.1.4		
Starting Point/Baseline:	There is no baseline established but will be in DY2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: [P-1] Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: No plan completed or documented Goal: Project Plan completed and ready for implementation Data Source: Plan documentation, meeting minutes and surveys Estimated Incentive Payment *(maximum amount):* $ 482.00 Process Milestone 2 [P-2]: Establish baseline rates P-2 Metric: Baseline rate established Baseline: No baseline number of individuals established Goal: Pre-Intervention rates established and being used for improvement guidelines Data Source: Plan and resource documentation, Initial Results Process Milestone 2 Estimated Incentive Payment: $ 482.00	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results Baseline: No data collected; no assessment results available Goal: Data system developed, tested and assessment results documented Data Source: Quality Improvement Records Process Milestone 3 Estimated Incentive Payment: $1,118.00 Outcome Improvement Target Milestone 4: ED utilization reduced for target condition Baseline: No baseline number of individuals established Goal: Pre-Intervention rates established for improvement guidelines	Outcome Improvement Target Milestone 5 [IT-9.2]: ED utilization reduced for target condition IT-5 Metric: Reduce ED visits for targeted behavioral health/ substance abuse patients Baseline: No ED visits reduced Improvement Goal/Target: ED visits reduced by TBD target amount Data Source: UM and encounter data records Outcome Improvement Target 5 Estimated Incentive Payment*:* $ 2,392.00	Outcome Improvement Target Milestone 6 [IT-9.2]: ED utilization reduced for target condition IT-6 Metric: Reduce ED visits for targeted behavioral health/ substance abuse patients Baseline: No ED visits reduced Improvement Goal/Target: ED visits reduced by TBD target amount Data Source: UM and encounter data records Outcome Improvement Target 6 Estimated Incentive Payment*:* $ 5,199.00

084434201.3.4	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.1.4		
Starting Point/Baseline:	There is no baseline established but will be in DY2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Data Source: UM and encounter data records Outcome Improvement Target 4 Estimated Incentive Payment*:* 1,118.00		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 964.00	Year 3 Estimated Outcome Amount: $ 2,236.00	Year 4 Estimated Outcome Amount: $ 2,392.00	Year 5 Estimated Outcome Amount: $5,199.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 10,791.00			

Outcome Measure (Improvement Target): IT-10.1: Quality of Life.
Unique RHP Outcome Identification Number: 084434201.3.5
Performing Provider & TPI: Texoma Community Center 084434201

Related Category 3 Outcome Measure(s): OD-10 Quality of Life/Functional Status

IT-10.1 Quality of life- (standalone measure)

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

Outcome Measure Description: **Outcome Measure Description**: Outcome Domain Measure "Quality of Life/Functional Status" (OD 10) was selected by Texoma Community Center (TCC) for the Category Three Outcome Measure for four of the five Projects. The interventions selected by TCC are all designed to improve a patient's access to care, enhance service array and ramp up the quality of care provided to current TCC patients as well as to additional patients seeking substance abuse treatment, counseling and physical health care by a primary care physician. Telehealth, telemedicine, telemonitoring and telementoring services will support, enhance and expand care to additional individuals and the Quality Improvement project will ensure that the services being provided are of top quality, cost efficient and continuously improving. All five projects will work together to improve access to care in order to positively impact patient functioning and quality of life in a variety of areas, as well as reduce the impact of mental illness, behavioral health issues and substance abuse problems on emergency rooms, acute care hospitals and psychiatric hospitals in the region.

Process Milestones: The Category 1 and Category 2 process milestones selected for Project 084434201.2.1 are as follows: DY2 (1) Identify and train BH case managers for blended services; DY 3 (2) Develop and put protocols and clinical guidelines in place, (3) Hire physician, nurse and clerical staff; (4) Implement services that will then establish the baseline for DY 4 and DY 5 improvements.

Outcome Improvement Targets: The selected Improvement Milestones for Project 084434201.2.1 are as follows: DY 4 (5) Increase use of routine preventive and primary care by 25% for identified "at risk" patients; (6) Increase use of routine preventive and primary care by 40% for identified "at risk" patients.

Category 3 Outcome targets are: DY 2 is Project Planning (engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans); DY 3 is for development and testing data systems and assess results; and DY 4 and DY 5 are designed for outcome improvement.

All TCC milestones are designed to ensure effective implementation of each project regardless of the project scope. For example, there are process milestones that plan, procure the necessary equipment and

service requirements, begin implementation to improve efficiency and clinical data access, enhance access across areas, site location milestones to add service sites, protocol and procedure milestones that will ensure quality service provision and milestones to add substance abuse treatment, counseling and physical health care to existing and new patients. Each project includes improvement milestones that will increase services to new patients over the course of the five years in addition to improving quality of care and collaboration of care with other providers in the region. The exact Category 3 improvement percentages will be determined in DY-2. TCC is poised to continue its current service improvement trend into the next four years and beyond.

Rationale: Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (42) Lost output and productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across all project areas will give a comprehensive picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report that "69 percent of adults w/SMI [with a severe mental illness] report at least one medical disorder" and that "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to the TCC Project of combining treatment for severe and persistent mental illness with primary care treatment for physical health disorders. Ms. Hyde goes on to report that: "Adverse childhood experiences (ACE, e.g., physical, emotional, and sexual abuse, as well as family dysfunction) [are] associated with mental illness, suicidality, substance abuse, and physical illnesses." She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care…" (43) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history. Providing primary care physician treatment along with psychiatric care, as well as ensuring quality improvements across all projects, will have an overall positive impact on patient functioning in the community and result in a reduction of health costs across the regional area.

The Quality of Life and Functional Status Outcome Measure is deemed to be the best quantifier, for this Local Mental Health Authority to use in assessing in impact of not only the individual projects, but to also assess the synergistic effect that all of the projects working together will have on improved patient experience and reduced health costs over time. (CN.2, CN.3,CN.5)

Outcome Measure Valuation: "The term *quality of life* (QOL) references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging." (44) This outcome measure will look at quality of life improvements to give definition to the size, scope, community benefit, and even efficiency and cost reduction/avoidance as each produces beneficial outcomes. The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. (9a)

Two studies were identified which featured alcohol and substance abuse treatment. A cost-utility study for substance/alcohol using treatment Buprenorphine (Shackman et al, 2012) that showed .22 QALYs gained for those receiving treatment. (9e) Drummond et al, (2009) looked at alcohol treatment in a

collaborative care setting, and QALYs increased by 0.0027. The average of these two values is 0.11135. (9f) Dewa et al. (2009) found that collaborative care saved $503 per patient in disability benefits. (9h) Another study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). In this study, the effect of the intervention was 0.0335 incremental life years gained. (9g)

Valuations should be based on economic evaluation principles that identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis is a useful tool for addressing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added. Cost-utility analysis (CUA) also measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Utilizing this methodology for the correlated Category 1 Project, the value will be $248,781.00 and benefit a minimum of 27 low-income individuals in this service area, with the related Category 3 valuation set at $ 33,239.00.

The quality improvement project will ensure that TCC is implementing best practices that reduce costs by applying the types of supports in the right amounts at the right time.

084434201.3.5	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.2.1		
Starting Point/Baseline:	Baseline Data to be determined in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: [P-1] Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: No Project Plan in place Goal: Project plan in place and ready for implementation Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,485.00 Process Milestone 2 [P-2]: Establish baseline rates P-2 Metric: AQoL Baseline rate established Baseline: No baseline number of individuals established Goal: AQoL Pre-Intervention Initial Scores established and being used for improvement guidelines Process Milestone 2 Estimated Incentive Payment: $ 1,485.00	Process Milestone 3 [P-3]: Develop and test data systems and assess results P-3 Metric: Data collection results & assessment results developed and tested Baseline: No systems in place or results assessed Goal: Data systems developed, tested and assessment results documented Data Source: Documentation of implementation, data collections and AQoL Surveys Rationale: Continuous Quality Improvement process is necessary to maintain best practices. Process Milestone 3 Estimated Incentive Payment: $ 3,443.50 Outcome Improvement Target Milestone 4 [IT-10.1]: Quality of Life IT-4 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline	Outcome Improvement Target Milestone 5 [IT-10.1]: Quality of Life IT-5 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: TBD % Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 5 Estimated Incentive Payment*:* $ 7,367.00	Outcome Improvement Target Milestone 6 [IT-10.1]: Quality of Life IT-6 Metric: Improved AQoL Outcomes Baseline: No improvement noted over established DY 2 baseline Goal: TBD % Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 6 Estimated Incentive Payment*:* $ 16,015.00

084434201.3.5	3.IT-10.1	Quality of Life/ Functional Status	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.2.1		
Starting Point/Baseline:	Baseline Data to be determined in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Goal: TBD % Improved AQoL scores documented Data Source: AQoL survey assessment results Outcome Improvement Target 4 Estimated Incentive Payment*:* $ 3,443.50		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 2,970.00	Year 3 Estimated Outcome Amount: $ 6,887.00	Year 4 Estimated Outcome Amount: $ 7,367.00	Year 5 Estimated Outcome Amount: $ 16,015.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 33,239.00			

Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 084434201.3.6
Performing Provider & TPI: Texoma Community Center 084434201

Outcome Measure Description: Reduce Emergency Department visits for target conditions:

- Behavioral Health/Substance Abuse

The process milestones selected to facilitate reporting outcomes for this Category Three Project will be as follows:

- P-1-- The Project Planning- engage stake holders, identify current capacity and needed resources.
- P-2—Establish baseline rates.
- P-5—Disseminate findings, including lessons learned and best practices, to stakeholders and other entities.

Outcome Measure Description: As capacity and resources are determined in Year 2, specific target improvement rates will then be determined and set. Based on past experience of TCC crisis staff, a reduction of emergency room visits can be expected as additional patients are stabilized through the utilization of planned programs. Part of the project will be to track and document outcomes of individuals with mental health, behavioral health, and substance abuse issues who present to emergency rooms for treatment. The goal is to reduce these ED visits over time. It is expected that all of TCC's PASS 1 projects (084434201.1.1, 084434201.1.2, 084434201.1.3 and 084434201.2.1) and PASS 2 project (084434201.2.2) can positively impact Category 3 Outcome Domain 9. Again, this will reduce costly emergency department visits and hospitalizations for the targeted individuals, as it did with TCC's ACT patients and other high-utilizing, at-risk psychosocial rehabilitation patients.

The selected Category 2 process milestones in the related project (084434201.2.2) are designed to ensure effective implementation of the project and facilitate improvement. The Process Milestone for DY 2 is: Design the community-based specialized interventions for the target populations, including significantly expanding the existing residential/respite facility. It is recognized that proper planning and designing is the foundation for project success.

DY 3 is "implementation year" and the process milestones are to: (1) Secure and ensure compliance of residential facility and enroll and serve individuals with targeted complex needs; and (2) Evaluate and continuously improve interventions using the "plan, do, study, act quality improvement cycles." These goals are self-evident in that success requires implementation of the resources needed and actualization of the interventions being used. DY 4 and DY 5 are about continuous expansion of services to increased numbers of patients (8 in DY 3, 20 in DY 4 and 28 in DY 5).

Both DY 4 and DY 5 have the same Outcome Improvement measures to monitor functional status with incrementing improvement percentages of 20% over baseline in DY4 and then 30% over baseline in DY5. Goals are in place to improve quality of care and collaboration with other providers in the region. TCC is poised to continue improvement trends into the next four years and beyond.

Process Improvement goals for this Category 3 Project are designed for project planning and implementation (engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans) and establishing baseline and goals. DY 4 and DY 5 have Improvement Target goals aimed at reducing emergency department visits so that when the baselines and target percentages are determined, the outcome data can be tracked and improvement trends documented. These interventions are expected to have positive outcomes across RHP 1.

Rationale: This Outcome Domain was selected by TCC for Project 084434201.2.2 since "Right Care, Right Setting" and reducing emergency department usage are TCC goals and regional goals. TCC will expand

treatment and, based on the reported past experience, have a solid positive impact on reducing emergency room, hospital and jail use by the target population. One way to do this is to improve overall patient functioning. This intervention expansion project will focus attention on the targeted Category 3 elements to reduce and lead to positive outcomes. Hyde reports in a SAMHSA presentation titled "Behavioral Health: Public Health Challenge Public Health Opportunity" that: "One-half of U.S. adults will develop at least one mental illness in their lifetime . . . Mental illness and heart diseases alone account for almost 70 percent of lost output/productivity." (11) Lost output and low productivity are evidence of quality of life and functional status problems, so targeting these issues as outcome measures across years will give a picture of how efficacious the intervention strategies are in terms of patient improvement. Patient improvement leads to health cost reductions having multiple levels of positive impact in the community. Ms. Hyde goes on to report: "Health care costs [are] higher with co-morbid BH [behavioral health] conditions" which lends support to efforts to stabilize individuals with co-occurring disorders. She explains that: "Today in America over 60 percent of people (> 26 million) who experience mental health problems and almost 90 percent of people (>20 million) who need substance abuse treatment do not receive care…" (12) These are the very people in the TCC service area who have the poorest quality of life and do not function as well in our communities as individuals with no trauma history.

The baseline target for this intervention effort will begin in DY 2 and be zero. While qualifying individuals are served by TCC already, the DY 3 enrollment assessments (ANSA) will be used for the expansion quality improvement baseline and improvement will be calculated as a percentage over these initial scores as if they are at zero.(CN.1, CN.2, CN.4, CN.5. CN.6)

Project Valuation: "Seventy percent of emergency department administrators report that they hold mentally ill patients for 24 hours or longer, according to a 2010 survey by the Schumacher Group, a Louisiana firm that manages emergency departments across the country. Ten percent said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER, increasing waiting times for all patients and overcrowding. The problem has worsened during the economic downturn. Since 2009, 32 states have cut their mental health budgets, largely from outpatient services that keep people healthy and out of the ER, according to a study by the National Alliance on Mental Illness, a patient advocacy group. And since 2010, states have closed or are planning to close nearly 4,000 state psychiatric beds, about 8 percent of capacity, according to the National Association of State Mental Health Program Directors Research Institute." (13) Emergency room care is costly and does not produce long-term results. Substantial value is inherent for both individuals and for the community-at-large as TCC implements its projects and focuses its attention on delivering the right care at the right time. Interventions with the target population, who are inclined to seek care through hospital emergency rooms, will reduce health care costs for an over-burdened medical system. Creating more effective treatment options will result in stabilization of individuals with mental illness and/or substance abuse issues. The World Health Organization (2003) states that community supports are: "Very cost effective in the community when primary care is linked to a network of services." (14) To this end, the projects will collectively and progressively increase value by using an array of community-based services as the right care is delivered in the proper location.

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

valuations fair across potentially different types of interventions, the common health goal, or outcome is the number of life-years added.

The benefits of the proposed program are valued based on a factoring process that included an extensive literature review of evidenced-based methodologies that researched the economic impact of specific interventions related to the project goals, such as homeless projects or Assertive Community Based Services interventions. TCC used these economic factoring numbers to determine the valuation of this project. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. **(9a)** One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, 2012). **(9g)** In this study, the effect of the intervention was 0.0335 incremental life years gained. Likewise, Dewa et al. (2009) found that collaborative care saved $503 per patient in disability benefits. **(9h)** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. **(9a)** Simon et al. (2012) found that collaborative health care yielded 47.7 additional depression-free days per year at a cost of $52 per depression-free day. **(9m)** Utilizing these methodologies, the related Category 2 Project's improved healthcare regional benefit is $80,248.00 with patient impact for 56 potential patients in RHP 1 and Outcome Measure value is $10,808.00 for a total of $91,056.00.

As with all of TCC's projects, focused attention will be given to serving people who are uninsured, under-insured or have Medicaid. It will continue, as it has, to look to foundations and fundraisers to augment existing services and support future service expansion.

Milestones/Metric Table:

084434201.3.6	3.IT-9.2	ED appropriate utilization (Standalone Measure)	
Texoma Community Center			084434201
Related Category 1 or 2 Projects:	084434201.2.2		
Starting Point/Baseline:	There is no baseline established but will be in DY2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: [P-1] Project Planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans P-1 Metric: Planning completed and documented. Baseline: No planning completed Goal: Appropriate Project plan in place and being implemented Data Source: Plan documentation, meeting minutes and surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 930.00	Process Milestone 2 [P-2]: Establish baseline rates P-2 Metric: Baseline established Baseline: No baseline number of individuals established Goal/Target: Pre-Intervention rates identified and established for improvement guidelines TBD Data Source: Plan and resource documentation, initial documented numbers Process Milestone 2 Estimated Incentive Payment: $2,206.00	Outcome Improvement Target Milestone 3 – [IT 9.3] —Right Care, Right Setting IT-3 Metric: Reduce ED visits for targeted behavioral health/ substance abuse patients Baseline: No ED visits reduced Improvement Goal/Target: ED visits reduced by TBD target amount Data Source: Hospital records/ UM, AQoL scores and crisis encounter data records Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 2,405 .00	Outcome Improvement Target Milestone 4 – OD 9—Right Care, Right Setting IT-4 Metric: Reduce ED visits for targeted behavioral health/ substance abuse patients Baseline: No ED visits reduced Improvement Goal/Target: ED visits reduced by TBD target amount Data Source: Hospital records/ UM, AQoL scores and crisis encounter data records Outcome Improvement Target 4 Estimated Incentive Payment*:* $5,266.00
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 930.00	Year 3 Estimated Outcome Amount: $2,206.00	Year 4 Estimated Outcome Amount: $2,405.00	Year 5 Estimated Outcome Amount: $5,266.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 10,807.00			

Outcome Measure (Improvement Target): IT-9.2 – ED Appropriate Utilization
Unique RHP Outcome Identification Number: 094095902.3.1
Performing Provider & TPI: Good Shepherd Medical Center 094095902

Rationale: The critical performance measure for rate of engagement will be important to determine clinical effectiveness of the program, adjustments that need to be made, and if there are lost opportunities to help the patient. Local emergency departments (ED) expend disproportionate resources toward psychiatric admissions that are non-medical in nature. This is a burden the ED experiences. Ensuring patients are seen at the right place at the right time is critical to increased efficiency and decreased costs.

Outcome Measure Valuation: Valuation of the project included cost avoidance with reduced Emergency Department costs for extended stay and repeat admissions of individuals that are non-medical in nature, but require a "safe environment". Similarly, an expected reduction of admissions and repeat admissions into the hospital through the ED is expected with an increased availability for the hospitals to treat non-psychiatric patients thereby generating revenue by admissions that are in the right place at the right time. An expected reduction of admissions to the state hospital will be achieved through wrap around services and keeping individuals in the community appropriately and preventing loss of work productivity for long periods of absence from the community. Transportation costs for the counties will be reduced and will free law enforcement to return to work "on the streets" for safety issues.

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **094095902.3.1**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-9.2**	*[Outcome Measure (Improvement Target) Title]* **ED appropriate utilization (Standalone measure)**	
Good Shepherd Medical Center			094095902
Related Category 1 or 2 Projects: 2.9 Establish/Expand a Patient Care Navigation Program	094095902.1.13		
Starting Point/Baseline: 500/yr			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-Y]: [*Insert specific language for selected process milestone if applicable*] P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Attendance lists & Written Implementation Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $102,431 **Process Milestone 2** P-2: Establish baseline rates: Data Source: 1.Establish base line ED admissions, 2. Establish baseline LOS in ED for psych admissions Process Milestone 2 Estimated Incentive Payment: $102,431	**Process Milestone 3** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: 1. ED admissions, 2. LOS in ED for psych admission Process Milestone 3 Estimated Incentive Payment: $55,781 **Outcome Improvement Target 1** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse Data Source: 1. ED admissions, 2. LOS in ED for psych admission Outcome Improvement Target 1 Estimated Incentive Payment*:* $55,781	**Outcome Improvement Target 2** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse by 5% over baseline Data Source: 1. ED admissions, 2. LOS in ED for psych admission Outcome Improvement Target 1 Estimated Incentive Payment*:* $148,750	**Outcome Improvement Target 3** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse 5% over baseline Data Source: 1. ED admissions, 2. LOS in ED for psych admission Outcome Improvement Target 1 Estimated Incentive Payment*:* $282,625

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **094095902.3.1**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-9.2**	*[Outcome Measure (Improvement Target) Title]* **ED appropriate utilization (Standalone measure)**	
Good Shepherd Medical Center			094095902
Related Category 1 or 2 Projects: 2.9 Establish/Expand a Patient Care Navigation Program	094095902.1.13		
Starting Point/Baseline: 500/yr			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $204,863	Year 3 Estimated Outcome Amount: $111,563	Year 4 Estimated Outcome Amount: $148,750	Year 5 Estimated Outcome Amount: $282,625
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $747,801			

Outcome Measure (Improvement Target): IT-6.1 – Percent improvement over baseline of patient satisfaction scores.
Unique RHP Outcome Identification Number: 094108002.3.1
Performing Provider & TPI: Mother Frances Hospital 094108002

Outcome Measure Description: To demonstrate improved access to primary care Mother Frances Hospital has selected Outcome Domain – 6 Patient Satisfaction and Improvement Target 6.1: Percent improvement over baseline of patient satisfaction scores.

Process Milestones: The team will select the CG-CAPHS patient satisfaction tool to begin the process of assessing the effectiveness of the expansion of primary care and the proposed interventions. Selected quality process milestones include DY2 (1) project planning, (2) establishing baseline rates, (3) developing and testing data systems, DY3 (4) performance improvement and (5) dissemination of findings and lessons learned to stakeholders.

Outcome Improvement Targets for each year: The outcome improvement target includes improvement over the baseline of patient satisfaction scores. Improvement targets are not yet determined, but the baseline and improvement targets for DY4 and 5 will be set in DY 2 and the data system tool implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures. Our goal will be to improve the patient satisfaction scores in the expanded and new clinics over the baseline in both DY4 and DY5.

Rationale: Process milestones P-1 through P- 5 were chosen due to the lack of accurate reports or no information. Current resources were not available to measure and monitor data. The data tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures.

The outcome improvement target includes improvement over the baseline of patient satisfaction scores. **Trinity Mother Frances Healthcare System has selected the Related Category 3 Outcome Measure: OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores. This will be done via the CG-CAPHS outpatient survey tool which will address multiple areas including: 1) getting timely care, appointments and information; 2) doctor communication; 3) doctor access to specialists; 4) involvement in shared decision making; and 5) overall health/functional status.**

Patient satisfaction and healthcare surveys are becoming a standard part of any hospital stay or doctor's office visit. We will utilize patient satisfaction surveys to provide feedback regarding the ease of accessing care in our facilities and to monitor satisfaction over time. Meeting the expectations of patients reinforces their involvement in healthcare[55].

Improvement target goal are not yet determined, but the baseline and improvement targets for DY 4 and 5 will be set in DY2 and the survey tool implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures. Our goal will be to improve targeted areas throughout the study period.

[55] Rao, J. et al. Visit-specific expectations and patient centered outcomes: a literature review. Arch Fam med. 2000. Nov/Dec 9(10: 1148-55.

There is currently no patient satisfaction program or survey in Trinity Clinic and has not been for the last five years. Expanding access will do little good if patients do not feel valued and have easy access to support they feel comfortable calling for assistance rather than just coming into the office for everything or going to the emergency room for care. To maximize the access and cost savings of this robust expansion of primary care, we must implement a robust customer service program based on the patient satisfaction scores.

Unfortunately, unless we train, implement, report, and hold individuals accountable, sustainable change to maximize new access points is unlikely to occur. Consequently, implementing a patient satisfaction program is critical to maximizing the success and outcomes of this project.

These surveys are designed to produce comparable data on the patient's perspective of care that allows objective and meaningful comparisons between institutions. Public reporting of the survey results is designed to create incentives for institution to improve their quality of care and enhance public accountability.

There are unique features about implementing this survey tool in collaboration with the Tyler Family Circle of Care and Trinity Clinic. Not only will this survey include a very focused population group of Medicaid and underserved patients, especially at the TFCC, but it will also reach out to a rural setting in Wood county and a more metropolitan area in Tyler. Assessment of the challenges and review of the results will be very valuable.

Outcome Measure Valuation: The valuation approach for outcome improvement target patient satisfaction is directly related to the valuation for increasing primary care capacity. The primary care project has set a goal of 45,000 patient visits over the term of the project. The number of patients participating in the survey program will not only be statistically valid but will reach across the outpatient system geographically, by expanded and new office location, and economically. To meet the statistically valid element the number of surveys will have to be increased in some areas.

The training and support services required to implement changes as required by the survey will have to be done across the region at multiple locations which will also impact the cost of this measure.

The valuation is based on the impact that strengthened primary care infrastructure will have on addressing the urgent need for primary care providers in NE Texas. Smith County is an underserved area where 21.7% of children live in poverty. The numbers only increase in the more rural areas. Medicaid clients will have few resources unless Tyler Family of Care and Trinity Clinic grow to expand access.[56] By adding mid-level providers, nurse/case managers, support staff, operational expenses, exam equipment, laboratory services, drugs, and a potential renovation of an existing office we hope to increase preventive health care services, early diagnoses, reduce preventable hospitalizations, and enhance appropriate use of emergency departments; all leading to increased health status and increased customer satisfaction.

Another issue considered is the impact of the costs of expanding primary care and the need for patients to see their new options as an excellent place to receive care or the CN.1 and CN.5 will not have been addressed.

[56] Texas Department of State Health Services, 2010.

The proposed valuation is based on adding mid-level providers, nurse/case managers, support staff, operational expenses, exam equipment, laboratory services, drugs, and a potential renovation of an existing office. Additional costs include survey tool costs, staff for analyzing results and leading improvement processes, and educational materials for patients.

In determining the valuation of this project the following criteria were considered: does it achieve the waiver goals, does it address community needs, what is the scope/size of the project, and what is the project investment. All of these areas rank very high and the impact on numerous points of entry for care were great.

094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	**094108002.1.1**		
Starting Point/Baseline:	*To Be Determined in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1P-1.1:Develop an implementation plan to improve patient satisfaction scores over baseline. Data Source:Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline: Identification of process. Goal: Take steps to implement improvement target. Rationale: The infrastructure will need to be planned and built to implement and measure patient satisfaction improvement outcomes. **Process Milestone 1 Estimated Incentive:$112,140** **Process Milestone 2 P-2:** Establish baseline rates. Metric 1 P-2.1: Determine current patient satisfaction levels for target primary care population.	**Process Milestone 4 P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1P-4.1: Conduct performance improvement activities with PDSA model to ensure reliable distribution, collection and data analysis. Data Source: Documentation/Report of PDSA cycle. Baseline/Goal: Performance improvement to meet improved target. Rationale: Performance improvement is necessary to implement best practices and refine process. **Process Milestone 4 Estimated Incentive Payment: $194,979** **Process Milestone 5 P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1P-5.1: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders.	**Outcome Improvement Target 1** IT-6.1: Improvement Target: Recent improvement over baseline of patient satisfaction scores. Numerator- Percent improvement in targeted patient satisfaction domain. Denominator- Number of patients who were administered the survey. Data Source: Patient survey. Baseline/Goal: DY 2 survey results/TBD **Outcome Improvement Target 1 Estimated Incentive Payment:$625,746**	**Outcome Improvement Target 2** IT-6.1: Improvement Target: Recent improvement over baseline of patient satisfaction scores. Numerator- Percent improvement in targeted patient satisfaction domain. Denominator- Number of patients who were administered the survey. Data Source: Patient survey. Baseline/Goal: DY 2 survey results/TBD **Outcome Improvement Target 2 Estimated Incentive Payment:$1,496,350**

094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	**094108002.1.1**		
Starting Point/Baseline:	*To Be Determined in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Current patient satisfaction data. Baseline/Goal: Establish baseline to determine improvement target. Rationale: It is necessary to measure current performance to plan improvement. **Process Milestone 2 Estimated Incentive Payment:$112,141** **Process Milestone 3 P-3:** Develop and test data systems. <u>Metric 1</u> P-3.1: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure patient satisfaction. Rationale: Testing the process to distribute, collect, and analyze the data points is necessary to validate data. **Process Milestone 3 Estimated Incentive Payment: $112,141**	Data Source: Documentation/Report of evaluation. Baseline/Goal: Educate stakeholders on quality outcome initiative/processes. Rationale: Stakeholder engagement is necessary to maintain best practices. **Process Milestone 5 Estimated Incentive Payment: $194,979**		

094108002.3.1	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	**094108002.1.1**		
Starting Point/Baseline:	*To Be Determined in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: **$336,422**	Year 3 Estimated Outcome Amount: **$389,958**	Year 4 Estimated Outcome Amount: **$625,746**	Year 5 Estimated Outcome Amount: **$1,496,350**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*:**$2,848,476**			

Outcome Measure (Improvement Target): IT-3.1 All Cause 30-day Re-admission Rate-NQF 1789rate.
Unique RHP Outcome Identification Number: 094108002.3.2
Performing Provider & TPI: Mother Frances Hospital 094108002

Outcome Measure Description: To demonstrate improved access to specialty care, Mother Frances Hospital has selected outcome domain – 3; Potentially Preventable Re-admissions-30 day readmission rates (PPRs) and improvement target; 3.1 All cause 30 day readmission rate – NQF 1789. The goal is to show definitively that having access to specialty care will impact readmission rates. In this case particularly, access to cardiology and pulmonology services will be a strong focus, as well as others as identified in the process.

Process Milestones: The team will first begin the process of assessing the effectiveness of selecting the expansion of specialty care and the impact on potentially preventable re-admission rates. Selected quality process milestones include in DY2: (1) project planning, (2) establishment baseline rates, (3) development and testing of data systems, and in DY3: (4) performance improvement and (5) dissemination of findings and lessons learned to stakeholders.

Outcome Improvement Targets for each year: The outcome improvement target includes improvement over the baseline of all cause 30-day re-admission rates. Improvement target goal are not yet determined, but the baseline and improvement targets for DY4 and 5 will be set in DY2 and the data system tool implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures. Our goal will be to improve the 30-day readmission rate over the baseline in both DY4 and DY5.
For all cause readmissions, the numerator will be all unplanned readmissions of patients over the age of 18 within 30 days of the discharge date of eligibility with the denominator all admissions for patients aged 18 years or older. The data source will be EHR and claims.

Rationale: The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmission may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rate.

Although some readmissions cannot be avoided because of progression of disease or expected worsening of chronic conditions, studies have demonstrated a wide range of 30-day readmissions (12-76%) which implies a direct relationship with the quality of care during the hospitalization and transition of care at discharge to home or another facility. (2,3). Multiple randomized trials have shown that readmission rates both overall or for specific disease states can be reduced 20-40 percent. (4,5)
Reducing preventable readmissions is a regional priority because reducing readmission positively correlates with improved chronic care management (CN.3) and effective healthcare delivery (CN.6). Mother Frances Hospital-Tyler will measure and report on the following all cause 30-day readmission rates.
Outcome Measure Valuation: The valuation approach for outcome improvement target all cause 30-day readmission rate is directly related to the valuation for expanding specialty care capacity. In addition, this project works in conjunction with the primary care and medical home projects Trinity Clinics is already engaged in to improve outcomes.

The proposed valuation is based on adding mid-level providers and specialty physician providers, support staff, and all the items that help make it easier for patient coordinated care. Specifically, this piece of the project requires a multidisciplinary team to gather data, review reports, develop plans and implement them. The mission of the waiver is reflected in the outcome goals of this quality outcome. Reducing the all cause 30-day readmission rate will result in improved chronic care management, reducing preventable hospitalizations, and will result in more effective and efficient delivery of health care in the region.

In determining the valuation of this project the following criteria were considered: does it achieve the waiver goals, does it address community needs, what is the scope/size of the project, and what is the project investment. All of these criteria rank very high and the impact on numerous points of entry for care were great.

Sources:

2. Benbasset, J. and Taragin, M. Hospital readmissions as a measure of quality of health care: advantages and limitations. Arch Inter Med 2000; 160(8):1074-81.
3. MedPAC . Report to the Congress promoting greater efficiency in Medicare. 2007.
4. Coleman, E. et al. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriar Soc. 2004: 52(11):1817-25.
5. Jack, B. et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Intern Med 2009; 150(3):178-87.

094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.1.2		
Starting Point/Baseline:	*To Be Determined in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1P-1.1:Develop an implementation plan to improve all cause 30-day re-admission rate NQF 1789. Data Source:Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline: Identification of process. Goal: Take steps to implement improvement target. **Process Milestone 1 Estimated Incentive Payment: $168,211** **Process Milestone 2 P-2:** Establish baseline rates. Metric 1 P-2.1: Determine current baseline rates in target primary care population. Data Source: EHR/Documentation of all cause 30-day re-admission rate.	**Process Milestone 4 P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1P-4.1: Conduct performance improvement activities with PDSA model to ensure reliable interactions, data collection, analysis, and reporting. Data Source: Documentation/Report of PDSA cycle. Baseline/Goal: Performance improvement to meet improved target. **Process Milestone 4 Estimated Incentive Payment:$292,468** **Process Milestone 5 P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1[P-5.1]: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report	**Outcome Improvement Target 1** IT-7.1: Improvement Target:All cause 30-day re-admission rate – NQF 1789. Numerator- The outcome for this measure is unplanned all-cause 30-day re-admission. Re-admission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All re-admissions are counted as outcomes except those that are considered planned. Denominator- This claims-based measure to be used is (2) Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. • Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion. Data Source:EHR, Claims. Baseline/Goal: TBD **Outcome Improvement Target 1 Estimated Incentive Payment:$938,620**	**Outcome Improvement Target 2** IT-7.1: Improvement Target: All cause 30-day re-admission rate – NQF 1789. Numerator- The outcome for this measure is unplanned all-cause 30-day re-admission. Re-admission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All re-admissions are counted as outcomes except those that are considered planned. Denominator- This claims-based measure to be used is (2) Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. • Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion. Data Source: EHR, Claims. Baseline/Goal: TBD **Outcome Improvement Target 2 Estimated Incentive Payment:$2,244,526**

094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.1.2		
Starting Point/Baseline:	*To Be Determined in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: Establish baseline to determine improvement target. **Process Milestone 2 Estimated Incentive Payment:$168,211** **Process Milestone 3 P-3:** Develop and test data systems. <u>Metric 1</u> P-3.1: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure all cause 30-day re-admission rate. Rationale: Testing the process to distribute, collect, and analyze the data points is necessary to validate data. **Process Milestone 3 Estimated Incentive Payment:$168,212**	of evaluation. Baseline/Goal: Educate stakeholders on quality outcome initiative/processes. **Process Milestone 5 Estimated Incentive Payment:$292,469**		

094108002.3.2	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.1.2		
Starting Point/Baseline:	*To Be Determined in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: **$504,634**	Year 3 Estimated Outcome Amount: **$584,937**	Year 4 Estimated Outcome Amount: **$938,620**	Year 5 Estimated Outcome Amount: **$2,244,526**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*:**$4,272,717**			

Outcome Measure (Improvement Target): IT-5.1-Improved cost savings: Demonstrate cost savings in care delivery
Unique RHP Outcome Identification Number: 094108002.3.3
Performing Provider & TPI: Mother Frances Hospital 094108002

Outcome Measure Description:
Trinity Mother Frances proposes to demonstrate cost savings by developing the capability to test methodologies for measuring cost containment. The implementation of a cost-accounting system will allow the System to measure the impact of various interventions.

Process Milestones and Metrics:

- DY 2: P-1; P-1.1
- DY 3: P-4, P-4.1; P-9; P-9.1
- DY 4: P-9; P-9.1
- DY 5: P-9; P-9.1; P-9.2

Improvement Milestones and Metrics:

- DY 4: I-7; I-7.1
- DY 5: I-7; I-7.1

Outcome Improvement Targets for each year:
The baseline and improvement targets for DY4 and 5 will be set in DY 2. The analysis tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures. Our goal will be to improve cost savings using cost benefit analysis. The outcome improvement target includes improvement over the baseline established using cost benefit analysis.

Rationale:
Process milestones P-1 through P- 5 were chosen due to the lack of accurate reports or no information. Current resources and processes were not available to accurately measure and monitor data. The analysis tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures.

Trinity Mother Frances has selected the related Project 3 category OD-5 IT 5.1 Improved Cost Savings. The emphasis in healthcare has shifted from quality to value with the recognition that cost must factor into all initiatives to improve healthcare delivery and utilization. Mother Frances Hospital is the highest valued safety net hospital in the region. Thus, the cost for care must be managed to be able to grow access points for care in both the primary and specialty care areas by working on clinical integration and care pathways. Cost benefit analysis will strengthen and quantify the quality impact.

Outcome Measure Valuation:
The valuation approach for the selected outcome improvement target to lower the average cost of care using cost benefit analysis is directly related to the value of expanding specialty care capacity and primary care and the medical home model currently used in Trinity Clinic. Developing clinical transformation protocols for care and developing tools to be able to value those decisions is a pathway to reach cost containment.

It is those very cost savings that will provide our system a stable financial platform to expand services and be able to recruit providers and establish high quality infrastructure. The implementation of the EPIC medical record system and mandating all hospital providers participate in that implementation of EPIC along with the adoption of certain new clinical transformational process that will lead to cost savings and higher quality outcomes.

The proposed valuation is based on having appropriate staffing for evaluation and development of process, support staff, operational expenses, electronic medical record systems and interfaces. In determining the valuation of this project the following criteria were considered: does it achieve the waiver goals, does it address community needs, what is the scope/size of the project, and what is the project investment. All of these criteria rank very high and the impact on numerous points of entry for care were great.

094108002.3.3	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.1		
Starting Point/Baseline:	*To Be Determined in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1P-1.1:Develop an implementation plan to improve cost savings through cost benefit analysis. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline/Goal: Identification of process/steps to implement improvement target. **Process Milestone 1 Estimated Incentive Payment:$93,450** **Process Milestone 2 [P-2]:** Establish baseline rates. Metric 1 P-2.1: Determine current baseline performance in target area. Data Source: Report of data analysis tools. Baseline/Goal: Establish baseline to determine improvement target.	**Process Milestone 4 P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1P-4.1: Conduct performance improvement activities with PDSA model to ensure reliable interactions, data collection, analysis, and reporting. Data Source: Documentation/Report of PDSA cycle. Baseline/Goal: Performance improvement to meet improved target. **Process Milestone 4 Estimated Incentive Payment: $162,482** **Process Milestone 5 P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1P-5.1: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report	**Outcome Improvement Target 1** IT-5.1: Improved cost savings: Demonstrate cost savings in care delivery. a) Type of analysis to be determined by provider: Cost Benefit Analysis. Data Source: TBD Baseline: New process. Goal: Demonstrate cost savings in care delivery. **Outcome Improvement Target 1 Estimated Incentive Payment:$521,455**	**Outcome Improvement Target 1** IT-5.1: Improved cost savings: Demonstrate cost savings in care delivery. a) Type of analysis to be determined by provider: Cost Benefit Analysis. Data Source: TBD Baseline: New process. Goal: Demonstrate cost savings in care delivery. **Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,246,958**

094108002.3.3	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.1		
Starting Point/Baseline:	*To Be Determined in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 2 Estimated Incentive Payment:$93,451 **Process Milestone 3 P-3:** Develop and test data systems. <u>Metric 1</u> P-3.1: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to improved cash savings. Rationale: Testing the process to distribute, collect, and analyze the data points is necessary to validate data. **Process Milestone 3 Estimated Incentive Payment:$93,451**	of evaluation. Baseline/Goal: Educate stakeholders on quality outcome initiative/processes. **Process Milestone 5 Estimated Incentive Payment: $162,483**		
Year 2 Estimated Outcome Amount: **$280,352**	Year 3 Estimated Outcome Amount: **$324,965**	Year 4 Estimated Outcome Amount: **$521,455**	Year 5 Estimated Outcome Amount: **$1,246,958**

094108002.3.3	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.1		
Starting Point/Baseline:	*To Be Determined in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*:**$2,373,730**			

Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization. (Stand alone measure)
Unique RHP Outcome Identification Number: 094108002.3.4
Performing Provider & TPI: Mother Frances Hospital 094108002

Outcome Measure Description: To demonstrate improved access to specialty care, Mother Frances Hospital has selected outcome domain – 9; Right Care, Right Setting. IT-9.2 ED appropriate utilization. The goal is to show definitively that having access to pediatric specialty and subspecialty care telemedicine consultations will support the appropriate utilization of ED services and improve the health of low-income children.

Process Milestones: The team will first begin the process of assessing the effectiveness of hiring a patient navigator for a pilot project in the emergency department and the impact on potentially preventable re-admission rates. Selected quality process milestones include in DY2: (1) project planning, (2) establishment baseline rates, (3) development and testing of data systems, and in DY3: (4) performance improvement and (5) dissemination of findings and lessons learned to stakeholders.

Outcome Improvement Targets for each year: The outcome improvement target includes improvement over the baseline of all pediatric patients seen in the ED and those requiring transfers without any telemedicine consults. Improvement target goal are not yet determined, but the baseline and improvement targets for DY4 and 5 will be set in DY2 and the data system tool implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures. Our goal will be to improve the transfer rate and the rate of consultations being done in the emergency department over the baseline in both DY4 and DY5. This will include data on the pediatric emergency department visits for pediatrics and those requiring a higher level of care than the current ED can provide.

Rationale: The relationship between hospital transfers rates and access to pediatric specialists and subspecialist and quality of care is well-documented, and is driven by a general consensus that access to care through telemedicine consultations will improve outcomes and allow for care to be given at the right place and at the right time which will then lower the cost of care.

Outcome Measure Valuation: The valuation approach used for the outcome improvement target of any pediatric visit to the emergency department or referral to the ED that requires pediatric specialty or subspecialty telemedicine consults. Mother Frances Hospital is actively engaged in a number of projects to improve quality of care and reduce costs. For pediatrics the addition of new providers is essential to meet those goals. However until the patient volume grows the best practice program to implement is telemedicine for these patients. Having a pediatric patient remain in their medical home for follow up care and close to home supports the family and lowers the cost of care. Just reducing the number of flights to Dallas for pediatric patients who need a consult is a significant savings. The long term value is that patients will be able to get high quality of care and diagnoses quicker and without traveling almost 100 miles for care. . Thus the value of this project is one that will be realized by both facilities and providers

In determining the valuation of this project the following criteria were considered: does it achieve the waiver goals, does it address community needs, what is the scope/size of the project, and what is the project investment. All of these criteria rank very high and the impact on numerous points of entry for care were great.

094108002.3.4	IT-9.2	ED Appropriate utilization- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.1.3		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 P-1.1: Develop an implementation plan to improve appropriate ED pediatric specialty consults. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline: Identification of process. Goal: Take steps to implement improvement target. **Process Milestone 1 Estimated Incentive Payment: $ 33,397** **Process Milestone 2 P-2:**	**Process Milestone 4 P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1 P-4.1: Conduct performance improvement activities with PDSA model to ensure reliable interactions, data collection, analysis, and reporting. Data Source: Documentation/Report of PDSA cycle. Baseline/Goal: Performance improvement to meet improved target. **Process Milestone 4 Estimated Incentive Payment: $59,402** **Process Milestone 5 P-5:** Disseminate findings, including lessons learned and best	**Outcome Improvement Target 1** IT-9.2: Improvement Target: Reduce the number of pediatric transfers without a specialty consult. Data Source: EHR, Claims. Baseline/Goal: TBD **Outcome Improvement Target 1 Estimated Incentive Payment: $194,220**	**Outcome Improvement Target 2** IT-9.2: Improvement Target: Reduce the number of pediatric transfers without a specialty consult. Data Source: EHR, Claims. Baseline/Goal: TBD **Outcome Improvement Target 2 Estimated Incentive Payment: $467,770**

Establish baseline rates. Metric 1 P-2.1: Determine current baseline rates in target ED population. Data Source: EHR/Documentation of all ED pediatric specialty consults. Baseline/Goal: Establish baseline to determine improvement target. **Process Milestone 2 Estimated Incentive Payment: $33,398** **Process Milestone 3 P-3:** Develop and test data systems. Metric 1 P-3.1: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process.	practices, to stakeholders. Metric 1 [P-5.1]: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation. Baseline/Goal: Educate stakeholders on quality outcome initiative/processes. **Process Milestone 5 Estimated Incentive Payment: $59,402**		

Baseline/Goal: Establish data collection process needed to measure ED visits. Rationale: Testing the process to distribute, collect, and analyze the data points is necessary to validate data. **Process Milestone 3 Estimated Incentive Payment: $33,398**			
Year 2 Estimated Outcome Amount: **$100,193**	Year 3 Estimated Outcome Amount: **$118,804**	Year 4 Estimated Outcome Amount: **$194,220**	Year 5 Estimated Outcome Amount: **$467,770**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$880,987**			

Outcome Measure (Improvement Target): IT-6.1 – Percent improvement over baseline of patient satisfaction scores –Breast Patient Navigator
Unique RHP Outcome Identification Number: 094108002.3.5
Performing Provider & TPI: Mother Frances Hospital 094108002

Outcome Measure Description: To demonstrate improved access to primary care Mother Frances Hospital has selected Outcome Domain – 6 Patient Satisfaction and Improvement Target 6.1: Percent improvement over baseline of patient satisfaction scores.

Process Milestones: The team will select the CG-CAPHS patient satisfaction tool to begin the process of assessing the effectiveness of the expansion of primary care and the proposed interventions. Selected quality process milestones include DY2 (1) project planning, (2) establishing baseline rates, (3) developing and testing data systems, DY3 (4) performance improvement and (5) dissemination of findings and lessons learned to stakeholders.

Outcome Improvement Targets for each year: The outcome improvement target includes improvement over the baseline of patient satisfaction scores. Improvement targets are not yet determined, but the baseline and improvement targets for DY4 and 5 will be set in DY 2 and the data system tool implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures. Our goal will be to improve the patient satisfaction scores in the expanded and new clinics over the baseline in both DY4 and DY5.

Rationale: Process milestones P-1 through P- 5 were chosen due to the lack of accurate reports or no information. Current resources were not available to measure and monitor data. The data tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures.

The outcome improvement target includes improvement over the baseline of patient satisfaction scores. **Trinity Mother Frances Healthcare System has selected the Related Category 3 Outcome Measure: OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores. This will be done via the CG-CAPHS outpatient survey tool which will address multiple areas including: 1) getting timely care, appointments and information; 2) doctor communication; 3) doctor access to specialists; 4) involvement in shared decision making; and 5) overall health/functional status.**

Patient satisfaction and healthcare surveys are becoming a standard part of any hospital stay or doctor's office visit. We will utilize patient satisfaction surveys to provide feedback regarding the ease of accessing care in our facilities and to monitor satisfaction over time. Meeting the expectations of patients reinforces their involvement in healthcare[57].

Improvement target goal are not yet determined, but the baseline and improvement targets for DY 4 and 5 will be set in DY2 and the survey tool implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures. Our goal will be to improve targeted areas throughout the study period.

[57] Rao, J. et al. Visit-specific expectations and patient centered outcomes: a literature review. Arch Fam med. 2000. Nov/Dec 9(10: 1148-55.

These surveys are designed to produce comparable data on the patient's perspective of care that allows objective and meaningful comparisons between institutions. Public reporting of the survey results is designed to create incentives for institution to improve their quality of care and enhance public accountability.

There are unique features about implementing this survey tool in collaboration with the Ross Breast Center and all the locations where they provide services along with other provider service locations that touch the patients being served through the program. Not only will this survey include a very focused population group of Medicaid and underserved patients, especially at the Ross Breast Center which serves Medicaid and other government payers and uninsured, but it will also reach out to a rural setting in multiple counties and a more metropolitan area in Tyler. Assessment of the challenges and review of the results will be very valuable.

Unless we train, implement, report, and hold individuals accountable, sustainable change to maximize the new navigation access service to assist patients who are at risk for being lost, denied, or unable to access services, the program will not be successful and the culture will not be changed. If those long-term goals are not met, then the project will not maximize its potential cost savings under the navigation project.

Outcome Measure Valuation: The valuation approach for outcome improvement target patient satisfaction is directly related to the valuation for increasing primary care capacity.

The valuation is based on the impact that targeted assistance to patients just diagnosed with cancer will have on addressing the ability to get patients scheduled for a surgical visit in 14 days rather than 30 and the support programs and community education to make a difference in patient satisfaction. Medicaid clients will have few resources unless Tyler Family of Care and Trinity Clinic grow to expand access[58] and address breast cancer support in a primary care setting. By adding a patient navigator dedicated to new breast cancer patients and providing direction and a focus on a continuum of care the goal should be achieved of increased customer satisfaction. Since a core duty of Navigator will be tracking and improving the length of time between diagnosis and treatment (surgery appointment) we should see a direct correlation in meeting our goal of improved patient satisfaction scores.

The proposed valuation is based on adding one patient navigator to serve 675 new cancer patients over the course of this project with support staff, operational expenses, and materials for the patients and family members. Additional costs include survey tool costs, staff for analyzing results and leading improvement processes, and educational materials for patients. Cross training of staff between providers will be critical to develop a life-line system for the patients and their families to have consistent care and support regardless of whether they are seeking services in primary care office, specialist, diagnostic service, support service, and in a rural or urban area.

In determining the valuation of this project the following criteria were considered: does it achieve the waiver goals, does it address community needs, what is the scope/size of the

[58] Texas Department of State Health Services, 2010.

project, and what is the project investment. All of these areas rank very high and the impact on numerous points of entry for care were great.

094108002.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores -	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	**094108002.2.2**		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 P-1.1: Develop an implementation plan to improve patient satisfaction scores over baseline. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline: Identification of process. Goal: Take steps to implement improvement target.	**Process Milestone 4 P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1 P-4.1: Conduct performance improvement activities with PDSA model to ensure reliable distribution, collection and data analysis. Data Source: Documentation/Report of PDSA cycle. Baseline/Goal: Performance improvement to meet improved target. Rationale: Performance improvement is necessary to implement best practices and	**Outcome Improvement Target 1** IT-6.1: Improvement Target: Recent improvement over baseline of patient satisfaction scores. Numerator- Percent improvement in targeted patient satisfaction domain. Denominator- Number of patients who were administered the survey. Data Source: Patient survey. Baseline/Goal: DY 2 survey results/TBD **Outcome Improvement Target 1 Estimated Incentive Payment*:* $77,688**	**Outcome Improvement Target 2** IT-6.1: Improvement Target: Recent improvement over baseline of patient satisfaction scores. Numerator- Percent improvement in targeted patient satisfaction domain. Denominator- Number of patients who were administered the survey. Data Source: Patient survey. Baseline/Goal: DY 2 survey results/TBD **Outcome Improvement Target 2 Estimated Incentive Payment*:* $187,108**

094108002.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores -	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.2		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Rationale: The infrastructure will need to be planned and built to implement and measure patient satisfaction improvement outcomes. **Process Milestone 1 Estimated Incentive: $13,359** **Process Milestone 2 P-2:** Establish baseline rates. Metric 1 P-2.1: Determine current patient satisfaction levels for target Ross Breast Center population. Data Source: Current patient satisfaction data. Baseline/Goal: Establish baseline to determine	refine process. **Process Milestone 4 Estimated Incentive Payment: $23,760** **Process Milestone 5 P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1 P-5.1: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation.		

094108002.3.5	IT-6.1	Percent improvement over baseline of patient satisfaction scores -	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.2		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
improvement target. Rationale: It is necessary to measure current performance to plan improvement. **Process Milestone 2 Estimated Incentive Payment: $13,359** **Process Milestone 3 P-3:** Develop and test data systems. Metric 1 P-3.1: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure patient satisfaction.	Baseline/Goal: Educate stakeholders on quality outcome initiative/processes. Rationale: Stakeholder engagement is necessary to maintain best practices. **Process Milestone 5 Estimated Incentive Payment: $23,761**		

094108002.3.5	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores -**	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	**094108002.2.2**		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Rationale: Testing the process to distribute, collect, and analyze the data points is necessary to validate data. **Process Milestone 3 Estimated Incentive Payment: $13,359**			
Year 2 Estimated Outcome Amount: **$40,077**	Year 3 Estimated Outcome Amount: **$47,521**	Year 4 Estimated Outcome Amount: **$77,688**	Year 5 Estimated Outcome Amount: **$187,108**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$352,394**			

Outcome Measure (Improvement Target): IT-3.1 All Cause 30-day Re-admission Rate-NQF 1789 rate.
Unique RHP Outcome Identification Number: 094108002.3.6
Performing Provider & TPI: Mother Frances Hospital 094108002

Outcome Measure Description: To demonstrate improved access to specialty care, Mother Frances Hospital has selected outcome domain – 3; Potentially Preventable Re-admissions-30 day readmission rates (PPRs) and improvement target; 3.1 All cause 30 day readmission rate – NQF 1789. The goal is to show definitively that having access to a care transition program with a collaborative program of protocols and policies will impact readmission rates. In this case particularly, access to standardize and best practices for discharge planning, analysis of drivers for 30-day readmissions, an integrated information system, clear identification processes for at risk patients, and a cross-continuum team working with these patients and their families will make a difference.

Process Milestones: Selected quality process milestones include in DY2: P-1 project planning, P-2 establishment baseline rates, P-3 development and testing of data systems, and in DY3: P-4 performance improvement and P-5 dissemination of findings and lessons learned to stakeholders.

Outcome Improvement Targets for each year: IT3.1 Our goal will be to improve the 30-day readmission rate over the baseline in both DY4 and DY5. Improvement targets for DY4 and 5 will be set in DY2 when the baseline rate is established.

For all cause readmissions, the numerator will be all unplanned readmissions of patients over the age of 18 within 30 days of the discharge date of eligibility with the denominator all admissions for patients aged 18 years or older. The data source will be EHR and claims.

Rationale: The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmission may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rate.

Although some readmissions cannot be avoided because of progression of disease or expected worsening of chronic conditions, studies have demonstrated a wide range of 30-day readmissions (12-76%) which implies a direct relationship with the quality of care during the hospitalization and transition of care at discharge to home or another facility. (2, 3). Multiple randomized trials have shown that readmission rates both overall or for specific disease states can be reduced 20-40 percent. (4,5)
Reducing preventable readmissions is a regional priority because reducing readmission positively correlates with improved chronic care management (CN.3) and effective healthcare delivery (CN.6). Mother Frances Hospital-Tyler will measure and report on the following all cause 30-day readmission rates.

Outcome Measure Valuation: The valuation approach for outcome improvement target all cause 30-day readmission rate is directly related to the valuation for development of the care transition program. In addition, this project works in conjunction with the primary care and medical home projects Trinity Clinics is already engaged in to improve outcomes and the ability

of a patient navigator to provide direction and support to ensure patients are being seen as the most cost effective and appropriate facility.

This project requires a multidisciplinary team to gather data, review reports, develop plans and implement them. The mission of the waiver is reflected in the outcome goals of this quality outcome. Reducing the all cause 30-day readmission rate will result in improved chronic care management, reducing preventable hospitalizations, and will result in more effective and efficient delivery of health care in the region.

In determining the valuation of this project the following criteria were considered: does it achieve the waiver goals, does it address community needs, what is the scope/size of the project, and what is the project investment. All of these criteria rank very high and the impact on numerous points of entry for care were great.

Sources:

6. Benbasset, J. and Taragin, M. Hospital readmissions as a measure of quality of health care: advantages and limitations. Arch Inter Med 2000; 160(8):1074-81.
7. MedPAC . Report to the Congress promoting greater efficiency in Medicare. 2007.
8. Coleman, E. et al. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriar Soc. 2004: 52(11):1817-25.
9. Jack, B. et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Intern Med 2009; 150(3):178-87.

094108002.3.6	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.3		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 P-1.1: Develop an implementation plan to improve all cause 30-day re-admission rate NQF 1789. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline: Identification of process. Goal: Take steps to implement improvement target.	**Process Milestone 4 P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1 P-4.1: Conduct performance improvement activities with PDSA model to ensure reliable interactions, data collection, analysis, and reporting. Data Source: Documentation/Report of PDSA cycle. Baseline/Goal: Performance improvement to meet improved target. **Process Milestone 4 Estimated Incentive Payment: $23,760**	**Outcome Improvement Target 1** IT-3.1: Improvement Target: All cause 30-day re-admission rate – NQF 1789. Numerator- The outcome for this measure is unplanned all-cause 30-day re-admission. Re-admission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All re-admissions are counted as outcomes except those that are considered planned. Denominator- This claims-based measure to be used is (2) Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age	**Outcome Improvement Target 2** IT-3.1: Improvement Target: All cause 30-day re-admission rate – NQF 1789. Numerator- The outcome for this measure is unplanned all-cause 30-day re-admission. Re-admission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All re-admissions are counted as outcomes except those that are considered planned. Denominator- This claims-based measure to be used is (2) Admissions to acute care facilities for patients aged 18 years or older. We have tested

094108002.3.6	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.3		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Estimated Incentive Payment: $13,359 **Process Milestone 2 P-2:** Establish baseline rates. Metric 1 P-2.1: Determine current baseline rates in target primary care population. Data Source: EHR/Documentation of all cause 30-day re-admission rate. Baseline/Goal: Establish baseline to determine improvement target. **Process Milestone 2 Estimated Incentive Payment: $13,359**	**Process Milestone 5 P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1 [P-5.1]: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation. Baseline/Goal: Educate stakeholders on quality outcome initiative/processes. **Process Milestone 5 Estimated**	groups. • Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion. Data Source: EHR, Claims. Baseline/Goal: TBD **Outcome Improvement Target 1 Estimated Incentive Payment: $77,688**	the measure in both age groups. • Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion. Data Source: EHR, Claims. Baseline/Goal: TBD **Outcome Improvement Target 2 Estimated Incentive Payment: $187,108**

094108002.3.6	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.3		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 P-3: Develop and test data systems. Metric 1 P-3.1: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure all cause 30-day re-admission rate. Rationale: Testing the process to distribute, collect, and analyze the data points is necessary to validate data.	**Incentive Payment: $23,761**		

094108002.3.6	IT-3.1	All cause – 30 day readmission rate- NQF 1789	
Mother Frances Hospital			094108002
Related Category 1 or 2 Projects:	094108002.2.3		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Estimated Incentive Payment: $13,359			
Year 2 Estimated Outcome Amount: **$40,077**	Year 3 Estimated Outcome Amount: **$47,521**	Year 4 Estimated Outcome Amount: **$77,688**	Year 5 Estimated Outcome Amount: **$187,108**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$352,394**			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 094127002.3.1
Performing Provider & TPI: ETMC Carthage 094127002

Outcome Measure Description: ETMC Carthage's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Panola County alone there were approximately 2,585 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $55M in charges.

TEXAS Department of State Health Services

Panola County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Panola County** received **$55,471,977** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Panola County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	120	115	111	100	91	101	638	$22,836	$14,569,133	$813
Dehydration	39	15	32	33	37	32	188	$15,977	$3,003,621	$168
Urinary Tract Infection	55	56	48	46	55	42	302	$15,971	$4,823,323	$269
Angina (without procedures)	22	38	18	7	13	9	107	$16,707	$1,787,698	$100
Congestive Heart Failure	145	92	116	91	109	85	638	$24,878	$15,872,028	$885
Hypertension (High Blood Pressure)	21	10	19	13	10	18	91	$19,067	$1,735,052	$97
Asthma	22	28	15	16	10	11	102	$15,457	$1,576,644	$88
Chronic Obstructive Pulmonary Disease	76	30	58	39	50	58	311	$20,860	$6,487,320	$362
Diabetes Short-term Complications	19	8	5	8	14	9	63	$14,820	$933,687	$52
Diabetes Long-term Complications	25	20	31	26	23	20	145	$32,300	$4,683,473	$261
TOTAL	**544**	**412**	**453**	**379**	**412**	**385**	**2,585**	**$21,459**	**$55,471,977**	**$3,094**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

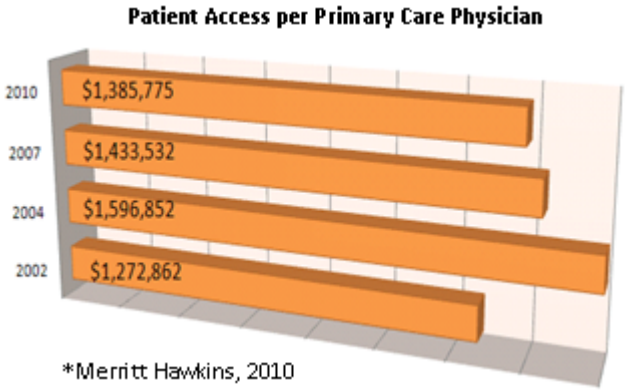
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data

on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

Applying the decreased utilization data values the savings at $.8M and the physician impact on access is valued at $1.3M. Accordingly, ETMC's average DSRIP funding request of approximately $.5M per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		3,165
ED visits / year / person		0.45
Potential ED Visits		1,427
ED Visits Reduced @ 15%		214
Avg ED Payment		$425
ED Savings	**$**	**90,987**
IP Admissions / year / person		0.11
Potential IP Admissions		361
Admissions Reduced @ 18%		65
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**801,961**
Total Estimated Savings	**$**	**892,948**



094127002.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Carthage			***094127002***
Related Category 1 or 2 Projects:	***094127002.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $43,415	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $50,324	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $80,752	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $193,103
Year 2 Estimated Total DSRIP Funding: $43,415	Year 3 Estimated Total DSRIP Funding: $50,324	Year 4 Estimated Total DSRIP Funding: $80,752	Year 5 Estimated Total DSRIP Funding: $193,103
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$367,594***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 094127002.3.2
Performing Provider & TPI: ETMC Carthage 094127002

Outcome Measure Description: ETMC Carthage's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Panola County alone there were approximately 2,585 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $55M in charges.

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From 2005-2010, adult residents (18+) of Panola County received **$55,471,977** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of Panola County	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	2005-2010	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	120	115	111	100	91	101	638	$22,836	$14,569,133	$813
Dehydration	39	15	32	33	37	32	188	$15,977	$3,003,621	$168
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Asthma	22	28	15	16	10	11	102	$15,457	$1,576,644	$88
Chronic Obstructive Pulmonary Disease	76	30	58	39	50	58	311	$20,860	$6,487,320	$362
Diabetes Short-term Complications	19	8	5	8	14	9	63	$14,820	$933,687	$52
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TOTAL	**544**	**412**	**453**	**379**	**412**	**385**	**2,585**	**$21,459**	**$55,471,977**	**$3,094**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease

avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $700,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $378,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		14,462
% Clinic Appropriate		15%
Clinic Appropriate Patients		2,169
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**922,799**
Clinic Payment @ 78% savings	$	203,016
Total Estimated Savings	**$**	**719,783**

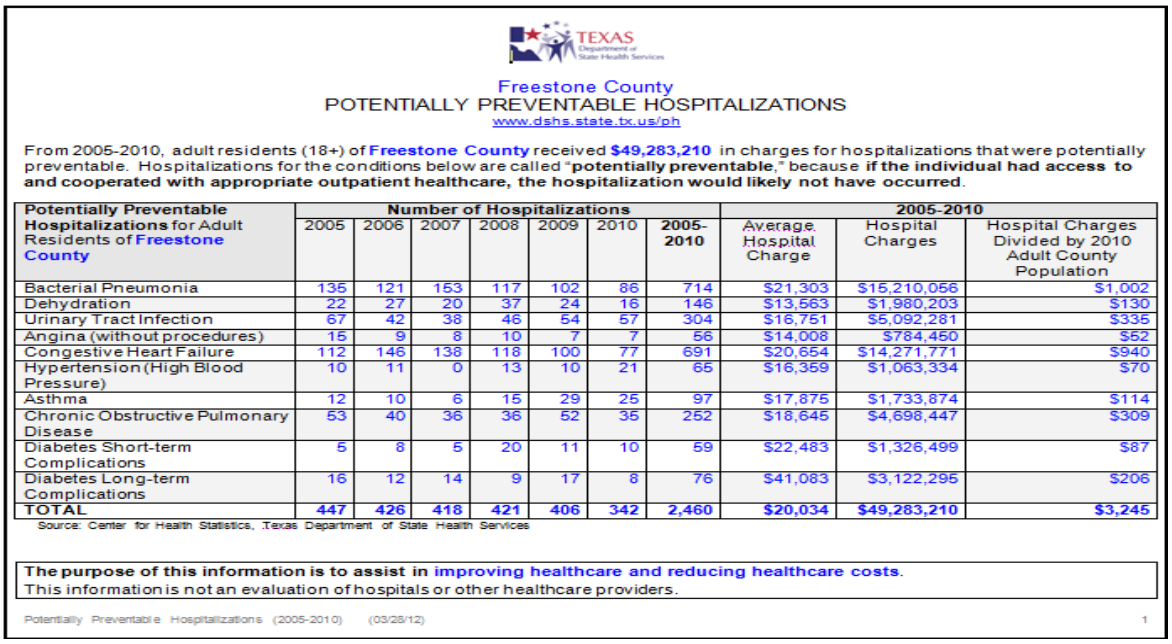
(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

094127002.3.2	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Carthage			***094127002***
Related Category 1 or 2 Projects:	***094127002.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $34,996	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $40,565	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $65,092	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $155,656
Year 2 Estimated Total DSRIP Funding: $34,996	Year 3 Estimated Total DSRIP Funding: $40,565	Year 4 Estimated Total DSRIP Funding: $65,092	Year 5 Estimated Total DSRIP Funding: $155,656
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$296,309***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 094190802.3.1
Performing Provider & TPI: ETMC Fairfield 094190802

Outcome Measure Description: ETMC Fairfield's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Dept of State Health Services suggests that in Freestone County alone there were approximately 2,460 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $49M in charges.



TEXAS Department of State Health Services

Freestone County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Freestone County** received **$49,283,210** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Freestone County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	135	121	153	117	102	86	714	$21,303	$15,210,056	$1,002
Dehydration	22	27	20	37	24	16	146	$13,563	$1,980,203	$130
Urinary Tract Infection	67	42	38	46	54	57	304	$16,751	$5,092,281	$335
Angina (without procedures)	15	9	8	10	7	7	56	$14,008	$784,450	$52
Congestive Heart Failure	112	146	138	118	100	77	691	$20,654	$14,271,771	$940
Hypertension (High Blood Pressure)	10	11	0	13	10	21	65	$16,359	$1,063,334	$70
Asthma	12	10	6	15	29	25	97	$17,875	$1,733,874	$114
Chronic Obstructive Pulmonary Disease	53	40	36	36	52	35	252	$18,645	$4,698,447	$309
Diabetes Short-term Complications	5	8	5	20	11	10	59	$22,483	$1,326,499	$87
Diabetes Long-term Complications	16	12	14	9	17	8	76	$41,083	$3,122,295	$206
TOTAL	**447**	**426**	**418**	**421**	**406**	**342**	**2,460**	**$20,034**	**$49,283,210**	**$3,245**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

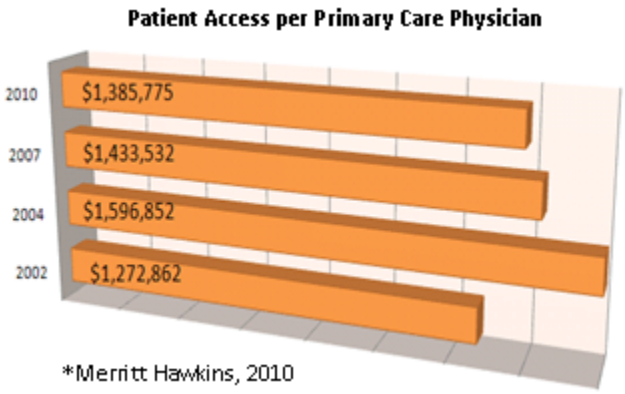
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental

patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $257,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $136,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		914
ED visits / year / person		0.45
Potential ED Visits		412
ED Visits Reduced @ 15%		62
Avg ED Payment		$425
ED Savings	**$**	**26,278**
IP Admissions / year / person		0.11
Potential IP Admissions		104
Admissions Reduced @ 18%		19
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**231,614**
Total Estimated Savings	**$**	**257,892**



094190802.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Fairfield			***094190802***
Related Category 1 or 2 Projects:	***094190802.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $12,655	**Process Milestone 2 Estimated Incentive Payment:** $14,668	**Outcome Improvement Target 1 Estimated Incentive Payment:** $23,538	**Outcome Improvement Target 2 Estimated Incentive Payment:** $56,285
Year 2 Estimated Total DSRIP Funding: $12,655	Year 3 Estimated Total DSRIP Funding: $14,668	Year 4 Estimated Total DSRIP Funding: $23,538	Year 5 Estimated Total DSRIP Funding: $56,285
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$107,146***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 094190802.3.2
Performing Provider & TPI: ETMC Fairfield 094190802

Outcome Measure Description: ETMC Fairfield's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Dept of State Health Services suggests that in Freestone County alone there were approximately 2,460 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $49M in charges.

TEXAS Department of State Health Services

Freestone County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Freestone County** received **$49,283,210** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Freestone County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	135	121	153	117	102	86	714	$21,303	$15,210,056	$1,002
Dehydration	22	27	20	37	24	16	146	$13,563	$1,980,203	$130
Urinary Tract Infection	67	42	38	46	54	57	304	$16,751	$5,092,281	$335
Angina (without procedures)	15	9	8	10	7	7	56	$14,008	$784,450	$52
Congestive Heart Failure	112	146	138	118	100	77	691	$20,654	$14,271,771	$940
Hypertension (High Blood Pressure)	10	11	0	13	10	21	65	$16,359	$1,063,334	$70
Asthma	12	10	6	15	29	25	97	$17,875	$1,733,874	$114
Chronic Obstructive Pulmonary Disease	53	40	36	36	52	35	252	$18,645	$4,698,447	$309
Diabetes Short-term Complications	5	8	5	20	11	10	59	$22,483	$1,326,499	$87
Diabetes Long-term Complications	16	12	14	9	17	8	76	$41,083	$3,122,295	$206
TOTAL	**447**	**426**	**418**	**421**	**406**	**342**	**2,460**	**$20,034**	**$49,283,210**	**$3,245**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease

avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $446,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $236,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		8,974
% Clinic Appropriate		15%
Clinic Appropriate Patients		1,346
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**572,617**
Clinic Payment @ 78% savings	$	125,976
Total Estimated Savings	**$**	**446,642**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

094190802.3.2	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Fairfield			***094190802***
Related Category 1 or 2 Projects:	***094190802.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $21,916	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $25,404	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $40,765	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $97,481
Year 2 Estimated Total DSRIP Funding: $21,916	Year 3 Estimated Total DSRIP Funding: $25,404	Year 4 Estimated Total DSRIP Funding: $40,765	Year 5 Estimated Total DSRIP Funding: $97,481
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$185,566***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 121817401.3.1
Performing Provider & TPI: ETMC Trinity 121817401

Outcome Measure Description: ETMC Trinity's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Trinity County alone there were approximately 2,511 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $66M in charges.

TEXAS Department of State Health Services

Trinity County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Trinity County** received **$66,542,171** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Trinity County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	101	75	96	88	80	75	515	$31,844	$16,399,594	$1,421
Dehydration	36	11	18	18	21	24	128	$14,900	$1,907,227	$165
Urinary Tract Infection	45	46	59	62	66	60	338	$21,944	$7,417,161	$643
Angina (without procedures)	8	8	0	0	7	6	0	$0	$0	$0
Congestive Heart Failure	129	96	101	83	93	113	615	$26,892	$16,538,834	$1,433
Hypertension (High Blood Pressure)	6	7	15	14	17	13	72	$21,736	$1,564,974	$136
Asthma	44	33	39	24	42	25	207	$21,540	$4,458,816	$386
Chronic Obstructive Pulmonary Disease	74	75	75	86	91	69	470	$26,302	$12,361,908	$1,071
Diabetes Short-term Complications	0	10	6	11	7	11	45	$24,557	$1,105,048	$96
Diabetes Long-term Complications	22	20	21	16	17	25	121	$39,575	$4,788,609	$415
TOTAL	**465**	**381**	**430**	**402**	**441**	**421**	**2,511**	**$26,500**	**$66,542,171**	**$5,764**

Source: Center for Health Statistics, Texas Department of State Health Services
The number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS.
Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

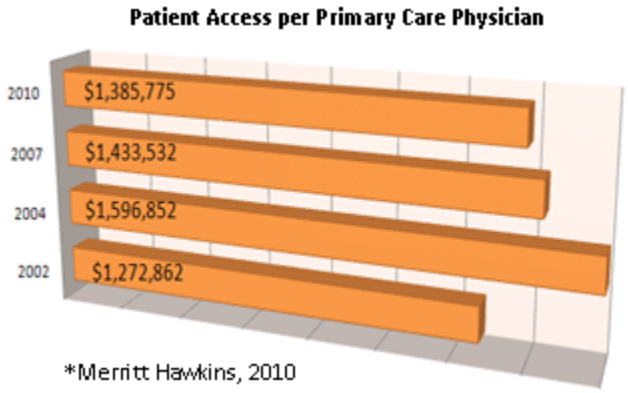
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data

on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $593,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $527,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		2,102
ED visits / year / person*		0.45
Potential ED Visits		948
ED Visits Reduced @ 15%		142
Avg ED Payment		$425
ED Savings	**$**	**60,429**
IP Admissions / year / person*		0.11
Potential IP Admissions		240
Admissions Reduced @ 18%		43
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**532,625**
Total Estimated Savings	**$**	**593,055**



121817401.3.1	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Trinity			***121817401***
Related Category 1 or 2 Projects:	***121817401.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $48,868	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $56,644	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $90,894	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $217,355
Year 2 Estimated Total DSRIP Funding: $48,868	Year 3 Estimated Total DSRIP Funding: $56,644	Year 4 Estimated Total DSRIP Funding: $90,894	Year 5 Estimated Total DSRIP Funding: $217,355
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$413,761***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 121817401.3.2
Performing Provider & TPI: ETMC Trinity 121817401

Outcome Measure Description: ETMC Trinity's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Trinity County alone there were approximately 2,511 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $66M in charges.

TEXAS Department of State Health Services

Trinity County
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From 2005-2010, adult residents (18+) of **Trinity County** received **$66,542,171** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Trinity County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	101	75	96	88	80	75	515	$31,844	$16,399,594	$1,421
Dehydration	36	11	18	18	21	24	128	$14,900	$1,907,227	$165
Urinary Tract Infection	45	46	59	62	66	60	338	$21,944	$7,417,161	$643
Angina (without procedures)	8	8	0	0	7	6	0	$0	$0	$0
Congestive Heart Failure	129	96	101	83	93	113	615	$26,892	$16,538,834	$1,433
Hypertension (High Blood Pressure)	6	7	15	14	17	13	72	$21,736	$1,564,974	$136
Asthma	44	33	39	24	42	25	207	$21,540	$4,458,816	$386
Chronic Obstructive Pulmonary Disease	74	75	75	86	91	69	470	$26,302	$12,361,908	$1,071
Diabetes Short-term Complications	0	10	6	11	7	11	45	$24,557	$1,105,048	$96
Diabetes Long-term Complications	22	20	21	16	17	25	121	$39,575	$4,788,609	$415
TOTAL	**465**	**381**	**430**	**402**	**441**	**421**	**2,511**	**$26,500**	**$66,542,171**	**$5,764**

Source: Center for Health Statistics, Texas Department of State Health Services
The number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS.
Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease

avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $382,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $340,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		7,692
% Clinic Appropriate		15%
Clinic Appropriate Patients		1,154
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**490,815**
Clinic Payment @ 78% savings	$	107,979
Total Estimated Savings	**$**	**382,836**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

121817401.3.2	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Trinity			***121817401***
Related Category 1 or 2 Projects:	***121817401.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $31,546	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $36,566	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $58,675	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $140,310
Year 2 Estimated Total DSRIP Funding: $31,546	Year 3 Estimated Total DSRIP Funding: $36,566	Year 4 Estimated Total DSRIP Funding: $58,675	Year 5 Estimated Total DSRIP Funding: $140,310
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$267,096***			

Outcome Measure (Improvement Target): IT-10.1 – Quality of Life
Unique RHP Outcome Identification Number: 121988304.3.1
Performing Provider & TPI: Lakes Regional MHMR Center 121988304

1. Outcome Description:

*In DY3, Process Measure (P-3) we will develop and test the data system for administration of validated assessment tool and EMR;

*In DY 4, Improvement Target-10.1 is to demonstrate a mean ~~10%~~ 7.5%% improvement over baseline in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for aggregate minimum of 418 individuals.

*In DY 5, Improvement Target-10.1 is to demonstrate a mean 10% improvement over baseline in quality of life (QOL) scores, as measured by evidence based and validated assessment tool for aggregate minimum of 715 individuals;

By the end of the waiver Year 5, our goal is to achieve a mean 10% improvement over baseline in the growing aggregate of QOL scores.

2. Rationale:

Process Milestone P-3 DY3 will involve developing and testing data systems for administration of the quality of life (QOL) validation assessment tool, to ensure accuracy and efficiency in the management and collection of data related to the Lakes Regional Mental Health Mental Retardation Center (LRMHMRC) Depression and Trauma Counseling Centers project. Improvement Targets 10-1 in DY's 4 and 5 will involve administration of the QOL assessment tool to project participants (target population) and determining percentage of improvement in QOL scores. According to the RHP Protocol (page 406), two (2) essential components of health-related quality of life are specific to improvement in symptoms and functioning. The RHP Protocol goes on to say that ". . .the best way to measure symptoms and functional status is by direct patient survey," since. . ."effective quality improvement requires relentless focus on the patient outcomes" (RHP Protocol, p. 406). Measuring improvement in Quality of Life will allow project staff to work collaboratively with the target population to highlight the importance of implementing evidence-based approaches to care that are tailored to the individual's needs. In addition, measuring improvement in QOL status will involve the target population in 1) being accountable for participation in consistent self-monitoring, and 2) exhibiting increased ability to manage challenging behaviors and symptoms, leading to greater quality of life satisfaction. A category 1 measure for this project is patent satisfaction which in concert with the outcome measure of quality of life satisfaction is in line with the Centers for Medicare and Medicaid Services (CMS) aim of enhancing the patient experience. Sharing survey results with other agencies and providers in the region in a semiannual face to face learning collaborative regarding improvement in QOL status for the target population will pave the way for other service providers to make improvements in their own approaches to the provision of health care leading to improved patient outcomes overall. Other providers in the region also will be made aware of the specialty needs of the target population and of efficacious, research-based approaches to provision of care that avert unnecessary placement of these individuals in more restrictive settings. As baseline data is established in DY2 refinement of gross estimates of improvement target yearly percentages is expected through the plan, do, act, study (PDSA) process.

3. Outcome Measure Valuation:

a. Approach/Methodology:

The project will implement outcome measure 3IT-10.1 to measure improvement of Quality of Life (QOL) scores. In keeping with the waiver Program Funding & Mechanics (PFM) Protocol for the DSRIP pool the approach to valuation followed the formula prescribed on page 27 of the document for Non-Hospital Performing Providers for Category 3 allowing DY2 5%, DY3 10%, DY4 10%, and DY5 20%. The Project Coordinator will ensure the protocol as set forth the SF-36 manuals will be followed for administering the QOL measure. This outcome measure will be valued by assessing community needs identified for Region 1 addressed through the RHP Plan, such as the need to address preventable acute care admissions and a need for additional health care providers who can address the specialty needs of the target population in a setting that is accessible. When patients do not have adequate supports and services in the community, they are more likely to utilize the emergency room (ER) and psychiatric hospital settings to manage crises which escalate due to inability to access the right level of services at the right time. This affects the target populations' overall perception of quality of life factors and leads to a cycle of ineffective coping and inability to manage behaviors in the community. Therefore, supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms and psychiatric hospitals is a predictor to overall improvement in coordinated care in the community, and greater QOL satisfaction.

DY3 – Process Milestone (P-3) will involve existing Information Technology and Quality Management staff to select and install data systems for electronic medical record (EMR), scheduling and system data collection connected to Lakes Regional MHMR Center (LRMHMRC) parent data system. The pre- and post-application of the survey and analysis of the data per individual will continue through DY5 to inform PDSA cycles.

DY4 – Improvement Target 10.1 is to establish an aggregate 10% improvement over individual entry baseline in QOL scores. Opening of services in DY3 will see the inclusion of the QOL instrument SF-36 at intake and the close of treatment (beyond screening and crisis stabilization) services for each individual participant of the Depression Trauma Counseling Center. Pre and post-scores consideration on ~~of~~ the same instrument in the individual's data will provide the outcome for each individual as well as across the services rendered. This QOL measure will be repeated for all treatment clients through FY5. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services ~~and in other barriers to access to care in the community for the target population~~, as well as improved ability to successfully and consistently self-manage challenging behaviors and symptoms in the community.

DY5 – Improvement Target 10.1 to maintain the aggregate mean 10% improvement in QOL scores over a growing number of participants. Since average length of stay is anticipated to be 7-10 weeks with 190 unique individual participants in the DY3 start-up and the clinic growth at 20% = 228 in DY4 and 30%=297 in DY5, the aggregate pool should grow beyond the minimum 715 unique individuals: See approach/methodology for IT-10.1 for DY4.

b. Rationale/Justification:

Outcome Measure:

3. IT-10.1 Quality of Life. The quality of life measure SP – 36 is a construction of 36 items categorized into eight (8) scales that create two summary measures: Physical Health and Mental Health. It has established validity and the MH scales have been shown to be useful in screening for psychiatric disorders.

Size:

The project will involve hiring 1 Program Coordinator who will administer QOL surveys, provide monitoring and follow-up and documentation of responses, and collection and maintenance of data on minimally 715 respondents receiving care in the project.

Project Scope:

The proposed project is projected to demonstrate and maintain a 10% mean improvement in Quality of Life factors as measured by a validated assessment tool by Year 5 in a minimum of 715 individuals utilizing the services in LRMHMRC RHP-1 counties.

Population Served:

The population targeted to be served is individuals who have depression or trauma related symptoms and lack the resources for private care including indigent, Medicaid or Medicare and do not otherwise qualify for state supported SMI services. This includes individuals referred by hospitals, police and other sources due to lack of ability to afford private care.

Community Benefit and Cost Avoidance:

Improved satisfaction with Quality of Life factors will lead to improved self-management of psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment" (RHP Protocol, page 398).

Addressing Priority Community Need:

Currently there is no accessible safety net program in the targeted area to serve the needs of the target population when in crisis, resulting in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals and institutional settings. The project relates to the Region 1 goals to improve (CN.2) Insufficient access to mental / behavioral health care services, and (CN.5) Inappropriate emergency department utilization.

4. **Related Category 1 and/or 2 projects linked to this outcome:**

121988304.1.1: Expand number of community based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression / Trauma Counseling Centers).

121988304.3.1	3. IT-10.1	Quality of Life	
Lakes Regional MHMR Center			TPI - 121988304
Related Category 1 or 2 Projects:	**121988304.1.1** *(Lakes Regional Depression / Trauma Counseling Centers)*		
Starting Point/Baseline:	New Project – Build baseline in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
N/A	**Process Milestone 1 [10.1 - P-4]:** Conduct PDSA cycles to improve data collection and intervention activities **Data Source:** PDSA program records. **Process Milestone 1 Estimated Incentive Payment: $129,903**	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life **Improvement Target:** Improvement of ~~10%~~ 7.5% in Quality of Life scores as measured by the SP-36 on aggregate treatment participants: minimum 418. **Data Source**: EMR, Project reports **Outcome Improvement Target 1 Estimated Incentive Payment: $141,615**	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life Improvement Target: Improvement of 10% in Quality of Life scores as measured by the SP-36 on aggregate treatment participants: minimum 715. **Data Source**: EMR, Project reports **Outcome Improvement Target 1 Estimated Incentive Payment: $375,834**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $N/A	Year 3 Estimated Outcome Amount: **$129,903**	Year 4 Estimated Outcome Amount: **$141,615**	Year 5 Estimated Outcome Amount: **$375,834**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 647,352			

Outcome Measure (Improvement Target): IT-~~6.1~~ 6.2 – Patient Satisfaction
Unique RHP Outcome Identification Number: 121988304.3.2
Performing Provider & TPI: Lakes Regional MHMR Center 121988304

1. **Outcome Description:**

   OD-6 Patient Satisfaction IT ~~6.1~~ 6.2 Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.

   *In DY3, Process Milestone 3 [P-4] Conduct Plan, Do, Study, Act cycles to improve data collection and intervention activities; the baseline for patient satisfaction with overall health status and/or functional status will also be established.
   *In DY 4 Outcome Improvement Target IT~~6.1~~ 6.2 - to achieve a 10% ~~15%~~ improvement over baseline of patient satisfaction scores in the aggregate.
   *In DY 5, Outcome Improvement Target IT~~6.1~~ 6.2 - to maintain a >15% improvement over baseline of patient satisfaction scores in the aggregate.

   By the end of the waiver, our goal is to achieve and maintain a >15% improvement over baseline of patient satisfaction scores regarding satisfaction with patient's overall health status/functional status.

2. **Rationale:**

   Lakes Regional MHMR Center (LRMHMRC) will integrate primary care services with the behavioral health services for the population of the clinics with Serious Mental Illness (SMI) who have no access to primary care services in the community thereby improving their whole person outcome. The state contracted services they are provided will change to the functional assessment of their condition and improvement on a quarterly basis through use of the Adult Needs and Skills Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment instruments. A project improvement tracking measure will be the SP-36 quality of life measurement to inform the individual and the project of the broader impact the service change is having. Finally, the outcome improvement target measure of the level of satisfaction with services using the validated instrument Mental Health Statistics Improvement Program Consumer Survey (MHSIP). Use of the MHSIP provides a standard instrument and protocol for data collection and processing consistent through the development for mental health programs with the effort of Center for Mental Health Services (CMHS) for improvement of state mental health programs (Green, R, & Newman, F., 1996). The MHSIP is a validated standardized instrument viewed as an equivalent alternative to the Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for outpatient mental health services. DY2 and DY3 efforts at establishing baselines will inform and likely lead to refinement of gross improvement target estimations.

   a. Outcome Measure Valuation:

   Approach/Methodology: In keeping with the waiver Program Funding & Mechanics Protocol (PFM) Protocol for the DSRIP pool the approach to valuation followed the formula prescribed on page 27 of the document for Non-Hospital Performing Providers for Category 3 allowing DY2 0-5%, DY3 10%, DY4 10%, and DY5 20%. The project will implement outcome measure 3.IT-~~6.1~~ 6.2 to measure improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status. This outcome

measure will be valued by assessing community needs identified for Region 1 addressed through the RHP Plan, such as the need for more care coordination and overuse of emergency department services. When patients experience a fragmented service system between behavioral health and primary care, as well as a lack of access to coordinated care, they experience lack of satisfaction and inability to self-monitor and manage symptoms effectively as a result. Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms and psychiatric hospitals is a predictor to overall improvement in coordinated care in the community, and greater quality of life satisfaction.

DY2 –Prepare the cultural changes in the organization through research in integrated care training of staff and preparations for the Care Integration Project and mobile medical clinic (CIP) - Establish baseline for improvement in patient satisfaction with overall health/functional status – Explore and connect clients to existing primary care resources where possible and preferred by the individual receiving services – Build the Care Integration Project program components.

DY3– Process Milestone P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities to inform and develop the project.

DY4 – Improvement Target ~~6.1~~ 6.2 to establish ~~15%~~ 10% improvement over baseline of patient satisfaction scores in selected domain. It is expected that service recipients of this integrated care project will experience improved overall satisfaction with services due to improved quality of life. Improved satisfaction is expected to lead to a decrease in overuse of emergency department services for the target population, as well as improved ability to successfully and consistently self-manage symptoms in the community.

DY5 – Improvement Target ~~6.1~~ 6.2 to maintain an aggregate 15% improvement over baseline of patient satisfaction scores in selected domain: See approach/methodology for **IT-~~6.1~~ 6.2 for DY4.**

b. Rationale /Justification:

Outcome Measure:

3.IT-6.1 Percent improvement over baseline of patient satisfaction scores. LRMHMRC will survey to establish the baseline for improvement in patient satisfaction with overall health/functional status; Improvement targets in DY's 4 and 5 will establish percent improvement over baseline in patient satisfaction scores, ending DY5 with a 15% improvement over baseline in patient satisfaction scores. LRMHMRC will employ the MHSIP instrument to provide a standardized method of collecting the data set. MHSIP is a validated survey instrument to assist states in improvement in Mental Health (MH) services developed by CMHS and Substance Abuse and Mental Health Services Administration (SMHSA) for community MH block grant requirements.

Size:

The project will be an Integrated Care Project serving three (3) mental health clinics weekly with a combined current population of 1,407 individuals. DY2 activity of surveying and establishing what portion of that population has an existing Primary Care Physician (PCP) relationship. The remainder with physical/chronic conditions needing regular care or

follow-up estimated to be in excess of 400 is the initial target population for the Care Integration Project at three existing mental health clinics.

Project Scope:
The proposed project is projected to measure satisfaction with improvement in overall health status/functional status in the targeted population in Camp, Delta, Franklin, Hopkins, Lamar, Morris and Titus counties.

Population Served:
The population targeted to be served are individuals with Severe Mental Illness (SMI).

Community Benefit and Cost Avoidance:
Improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing, monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for incremental care. Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment" (RHP Protocol, page 398).

Addressing Priority Community Need:
In keeping with the Region 1 results of the Community Needs Assessment, this population particularly has (CN.1) Insufficient access to primary and specialty health care services with (CN.3) High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer. This lack of access results in (CN.5) Inappropriate emergency department utilization and (CN.4) High costs due to potentially preventable hospital admissions/readmissions.

Reference

Green, R. S. & Newman, F. L., The Final Report of the Mental Health Statistics Improvement Program (MHSIP), Task Force on a Consumer-Oriented Mental Health Report Card, SAMHSA, CMHS, April, 1996.

121988304.3.2	*3.IT- ~~6.1~~ 6.2*	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			*121988304*
Related Category 1 or 2 Projects:	**121988304.2.1 (**Lakes Regional Care Integrated Project)		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 1 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project operational plan and PDSA reports. **Metric 1:** Program Implementation Plan, PDSA cycle documentation, Baseline data. **Process Milestone** 1 Estimated Incentive Payment: $85,750	Outcome Improvement Target 1 [IT-~~6.1~~ 6.2]: Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure) Four (4) primary focus areas of the MHSIP are : 1) General satisfaction 2) Access 3) Quality / appropriateness and 4) Outcomes. Data Source: MHSIP surveying of participants Improvement Target: 10% ~~15%~~ improvement over baseline of patient satisfaction scores Metric: Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Data Source: Patient MHSIP Survey Outcome Improvement Target 1 **Estimated Incentive Payment*:* $89,080**	Outcome Improvement Target 1 [IT-~~6.1~~ 6.2]: Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure) Four (4) primary focus areas of the MHSIP are : 1) General satisfaction 2) Access 3) Quality / appropriateness and 4) Outcomes. Data Source: MHSIP surveying of participants Improvement Target: 15% improvement over baseline of patient satisfaction scores Metric: Numerator: Percent improvement in targeted patient satisfaction domain. Denominator: Number of patients who were administered the survey. Data Source: Patient MHSIP Survey Outcome Improvement Target 1 **Estimated Incentive Payment*:* $115,036**

121988304.3.2	*3.IT- ~~6.1~~ 6.2*	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			*121988304*
Related Category 1 or 2 Projects:	**121988304.2.1 (**Lakes Regional Care Integrated Project)		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: N/A	**Year 3 Estimated Outcome Amount**: $ **85,750**	**Year 4 Estimated Outcome Amount: $89,080**	**Year 5 Estimated Outcome Amount: $115,036**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* **$289,866**			

Outcome Measure (Improvement Target): IT-6.1 – Patient Satisfaction
Unique RHP Outcome Identification Number: 121988304.3.3
Performing Provider & TPI: Lakes Regional MHMR Center 121988304

1. Outcome Description:

*In DY3, Process Milestone 1 [P-4] Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities.

*In DY4 Outcome Improvement Target IT6.1- to achieve a mean of ~~10%~~ 7.5% improvement over baseline of per individual patient satisfaction scores.

*In DY5, Outcome Improvement Target IT6.1- to achieve a mean of 10% improvement over baseline of per individual patient satisfaction scores.

By the end of the waiver, the goal of LRMHMR is to maintain an average 10% improvement over individual baseline of per individual satisfaction scores with program participants' overall health status/functional status.

2. Rationale:

The project is to introduce in Hunt County the Individualized Self Health Action Plan for Empowerment (In SHAPE) program thereby improving their physical health knowledge and functioning in a normalized setting. The state has mandated a change to the functional assessment of individuals with SMI enrolled in services on a quarterly basis through use of the Adult Needs and Skills Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment instruments. A project improvement tracking measure will be the SP-36 quality of life measurement to inform the individual and the project of the broader impact the service change is having. Finally, the outcome improvement target measure of the level of satisfaction with services using the validated instrument Mental Health Statistics Improvement Program Consumer Survey (MHSIP). Patient satisfaction is vital to the process of making fundamental shifts in consciousness and habits addressed in the program for sustained learning and integration into daily activities. Satisfaction and recognition of functional improvements (as in the SP-36) will help individuals maintain benefits and attitudes developed in the program to bring about the longer term health results and cost savings the Waiver seeks to achieve. Use of the MHSIP provides a standardized instrument and protocol for data collection and processing consistent with the effort of Center for Mental Health Services (CMHS) for improvement of state mental health programs. DY2 and DY3 efforts at establishing baselines will inform and likely lead to refinement of gross improvement target estimations.

3. Outcome Measure Valuation:

a. Approach/Methodology: The project will implement outcome measure IT-6.1 to measure improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status. This outcome measure will be valued by assessing community needs identified for Region 1 addressed through the RHP Plan, such as the need for more care coordination and reduction of overuse of emergency department services. When patients experience stagnation after stabilization on medications but have no effective service for life improvement in the prodromal aspects of their illness, they

experience lack of satisfaction and inability to self-monitor and manage symptoms effectively as a result. Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms and psychiatric hospitals is are related effects of overall improvement in self-management of health, functioning and personal efficacy in the community, and greater quality of life satisfaction in people with serious mental illness (SMI).

DY3– Process Milestone (P-4): conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities will inform the project for continuous quality improvement.

DY4 – Improvement Target 6.1: to establish a mean of 10% improvement over baseline of individual patient satisfaction scores in selected domain. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and other barriers to access to care in the community for the target population, as well as improved ability to successfully and consistently self-manage symptoms in the community.

DY5 – Improvement Target 6.1: to establish a mean of 10% improvement over baseline of individual patient satisfaction scores in selected domain: See approach/methodology for IT-6.1 for DY4**.**

b. Rationale/Justification:

Outcome Measure: IT-6.1 Percent improvement over baseline of patient satisfaction scores. A preparation activity will establish baseline for individual participant improvement in patient satisfaction with overall health/functional status; Improvement targets in DY4 and DY5 will establish percent improvement over baseline in patient satisfaction scores, ending DY5 with a mean 10% improvement over baseline in patient satisfaction scores for all participants. Since satisfaction with services has been generally high in past surveys on another instrument, a mean 10% improvement over each participant's baseline within program is thought to be challenging. Further, maintaining the 10% mean for the revolving groups of participants increases the challenge and the impact of the project by the numbers improving.

Size – The project will be In SHAPE serving eighteen (18) mental health clinic clients weekly over a six (6) month period over the course of DY3, 4 & 5 with the intent of graduating a minimum of 89. DY2 activity is surveying and establishing what portion of the clinic population would meet inclusion criteria.

Project Scope – The proposed project is projected to measure satisfaction with improvement in overall health status/functional status in the targeted population of identified eligible individuals in the LRMHMRC office in Greenville, TX.

Population Served – The population targeted to be served are individuals stable on medications with SMI.

Community Benefit and Cost Avoidance – Improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment" (RHP Protocol, page 398).

Addressing Priority Community Need– In keeping with the Region 1 results of the Community Needs Assessment, this population particularly has needs addressed in:

- CN.3 High rates of chronic disease, including diabetes, heart disease, asthma, obesity, and cancer
- CN.4 High costs due to potentially preventable hospitalizations.

4. Related Category 1 and/or 2 project linked to this outcome:

121988304.2.2 Design, implement, and evaluate research – supported and evidence-based interventions tailored towards individuals in the target population (Lakes Regional MHMR Center In SHAPE Project).

121988304.3.3	*IT- 6.1*	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			*121988304*
Related Category 1 or 2 Projects:	121988304.2.2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting. (In SHAPE)		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
N/A – Starts in DY-3	**Process Milestone 1** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project operational plan and PDSA reports. **Process Milestone 1 Estimated Incentive Payment**: **$18,111**	**Outcome Improvement Target 1 [IT-6.1]:** Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the MHSIP survey may be used to establish if patients: (1) are getting timely care, appointments, and information; (Standalone measure) (2) how well their doctors / providers communicate; (Standalone measure) (3) patient's involvement in shared decision making, and (Standalone measure) (4) Patient's overall health status/functional status. **Data Source:** MHSIP surveying of participants **Improvement Target**: 7.5% ~~10%~~ mean improvement over baseline of patient satisfaction scores for growing aggregate of treatment participants.	**Outcome Improvement Target 1 [IT-6.1]:** Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the MHSIP survey may be used to establish if patients: (1) are getting timely care, appointments, and information; (Standalone measure) (2) how well their doctors / providers communicate; (Standalone measure) (3) patient's involvement in shared decision making, and (Standalone measure) (4) Patient's overall health status/functional status. **Data Source:** MHSIP surveying of participants **Improvement Target**: 10% mean improvement over baseline of patient satisfaction scores for growing aggregate of treatment participants.

121988304.3.3	*IT- 6.1*	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			*121988304*
Related Category 1 or 2 Projects:	121988304.2.2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting. (In SHAPE)		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Metric: **Numerator:** Percent improvement in targeted patient satisfaction domain. **Denominator:** Number of patients who were administered the survey. **Data Source**: Patient MHSIP Survey **Outcome Improvement Target 2** Estimated Incentive Payment*:* **$20,994**	**Metric:** **Numerator:** Percent improvement in targeted patient satisfaction domain. **Denominator:** Number of patients who were administered the survey. **Data Source**: Patient MHSIP Survey **Outcome Improvement** Target 3 Estimated Incentive Payment*:* **$41,786**
Year 2 Estimated Outcome Amount: N/A	**Year 3 Estimated Outcome Amount**: **$18,111**	**Year 4 Estimated Outcome Amount: $20,994**	**Year 5 Estimated Outcome Amount**: **$41,786**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** **$80,891**			

Outcome Measure (Improvement Target): IT- 7.8 - Chronic Disease Patients Accessing Dental Services
Unique RHP Outcome Identification Number: 127278302.3.1
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Process outcomes selected for DY2 and DY3 are directly related to initial components of this initiative including the establishment of a memorandum of understanding between UPA/UTHSCT and the Dental Hygiene Program at TJC. As construction of new clinic space moves forward at TJC with anticipated occupation of 30 new state-of-the-art dental operatories by the fall of 2014, interdisciplinary training will move forward along with initiation of new and expanded clinics for this population of patients in current facilities at TJC. Improving access to dental preventive services will be achieved through a series of steps to incorporate the **core project component** as specified in Category 1 and Category 3 of the RHP Planning Protocol (Texas Health and Human Services Commission, 2012) – "increase and expand services by increasing clinics . . . or other approaches to increase oral health services to underserved populations; patients are more likely to seek dental services when the importance of need is documented by a formal referral being made."

- A **gap** in access to preventive dental services and education has been identified. The initial step will be to develop/implement a dental preventive services and patient education access **plan** which addresses this newly available service for patients of this network of clinics. These services will include initial and follow-up examinations, basic/fundamental dental imaging, adult and child prophylaxis including cleaning, sealants, fluoride varnish applications, etc., and dental care education. A modest visit co-pay will be applied.
- Recruit and/or negotiate arrangements for dentist/dental hygiene faculty to have joint appointments between UPA/UTHSCT and TJC
- **Train/educate** project team professionals on processes, guidelines, and technology which will optimize timely referrals to and consultations for dental preventive services
- Implement coordinated referrals across the network of clinics
- Conduct **quality improvement** activities to identify barriers to timely referral consultation, assess success of bidirectional communication between primary care and dental providers through efforts to integrate oral health information with electronic medical records where possible, etc. Plan-Do-Study-Act (PDSA) or similar methodology will be used.

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, a single standalone measure is selected from the domain Oral Health (OD-7). Specifically, this will be IT-7.8, Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider. As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: Evidence suggests that untreated oral disease can lead to serious and sometimes life threatening conditions which can be complicated by emergency department visits and extended hospital stays. (TDA, 2008) Diabetics with severe gum disease are three times more likely to succumb to

combined renal/cardiac dysfunction compared with groups with lesser gum disease. These oral health conditions are largely preventable through improved access to dental preventive services. Through collaboration with a well established dental hygiene training program at TJC and a new state-of-the-art facility currently under construction, the patients of the UPA/UTHSCT network of ambulatory clinics, will gain access to dental preventive services and patient education previously unavailable. The result will be improved patient experience, reduced overall turnaround time for dental procedures, and improved efficiency of practitioners. The ultimate **focus** of this intervention in **RHP 1** is to **improve health outcomes of the lower income populations** that are disproportionately affected. For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: Oral health is recognized as an important contributor to overall health. (IOM, 2005) There have been recent links between oral health, periodontal disease (4-12% of U.S. adults), and oral infections with other health conditions such as diabetes, cardiovascular disease, premature/low-weight births, and bacterial pneumonia. (de Oliveira et al., 2010; CDC, 2011; TDA, 2008) Most oral diseases are preventable with population-based and community approaches. Untreated oral disease can lead to serious and sometimes life threatening conditions which can be complicated by emergency department visits and extended hospital stays. (TDA, 2008) This project is intended to improve access to dental preventive services to the UPA/UTHSCT network of clinics and patient population (Smith, Upshur, and Rusk Counties). Development and implementation of a plan to increase access to dental preventive services previously unavailable to vulnerable rural patients will help to create an efficient referral system resulting in timely care. Use of Category 3, evidence-based outcome measures which demonstrate this level of increased access is intended to improve quality of care. This infrastructure investment to build capacity in dental personnel will simultaneously help to reduce the financial costs to the regional health care system through provision of preventive dental services recognized to reduce the burden of chronic disease. The value of this project is justifiable on the basis of:

- Addressing CN.1, insufficient access to primary and specialty health care, as well as CN.6, efficiency in and effectiveness of health care delivery.
- Enhanced access to dental preventive services for a rural/vulnerable population and to promote early intervention measures which may contribute to the reduction of chronic disease morbidity.
- Improved coordination of care resulting in more timely delivery.
- Building capacity and sustainability through process development, recruitment and training of dental professionals, and training family medicine residents in appropriate referral for oral health services.
- Engagement of large stakeholders in collaborative service delivery in RHP 1.

References:

Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health. Oral health: preventing cavities, gum disease, tooth loss, and oral cancers, 2011. Available at: http://www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm (last accessed 10-13-2012).

Institute of Medicine. Quality through collaboration: the future of rural health. Washington, D.C.: The National Academies Press, 2005, 288 pp. Available at http://www.nap.edu/catalog/11140.html (last accessed 10-01-2012).

de Oliveira C, Watt R, Hamer M. Toothbrushing, inflammation, and risk of cardiovascular disease: results from Scottish Health Survey. *BMJ* 2010;340:c2451. Available at http://www.bmj.com/content/340/bmj.c2451.pdf%2Bhtml (last accessed 10-13-2012).

Texas Dental Association (TDA). Building better oral health, 2008. Available at: http://www.buildingbetteroralhealth.org/ (last accessed 10-13-2012).

Texas Health and Human Services Commission. Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

127278302.3.1	*3.IT-7.8*	Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	*127278302.1.1*		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of planning and Memorandum of Understanding Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $129,836 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $61,491 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $61,491	**Outcome Improvement Target 1** IT-7.8: Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $253,024	**Outcome Improvement Target 2** IT-7.8: Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $442,506
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $129,836	Year 3 Estimated Outcome Amount: $122,982	Year 4 Estimated Outcome Amount: $253,024	Year 5 Estimated Outcome Amount: $442,506
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $948,348			

Outcome Measure (Improvement Target): IT-1.12 Diabetes care: *Retinal eye exam*
Unique RHP Outcome Identification Number: 127278302.3.32 Pass 3b (127278302.3.2)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Process outcomes selected for DY2 and DY3 are directly related to initial components of this initiative. Improving access to specialty care will be achieved through a series of steps to incorporate **core project components** as specified in Category 1 of the RHP Planning Protocol (Texas Health and Human Services Commission, 2012) as follows:

- Confirm specialty care **gaps** early. Targeted specialties of interest for consideration include ophthalmology, podiatry, nephrology, endocrinology/diabetes care, neurology/pain, infectious diseases, dermatology, and rheumatology
- Develop/implement a specialty care access **plan** which addresses targeted gaps in specialty care for this network of clinics as well as potential referrals from Good Shepherd Medical Center (GSMC) Internal Medicine Residency (IMR)
- Recruit or negotiate arrangements to fill these gaps within the UPA patient care network of clinics
- **Train/educate** healthcare team professionals on processes, guidelines, and technology which will optimize timely referrals to and consultations by selected medical specialties
- Increase service availability and specialty clinic locations
- Implement coordinated referrals across the network of clinics
- Conduct **quality improvement** activities to identify barriers to timely referral consultation, e.g., Plan-Do-Study-Act (PDSA)

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Chronic Disease Management (OD-1). For this unique Category 3 outcome measure, this will include Diabetes care: *Retinal eye exam* (IT-1.12). As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States, frequently undiagnosed. (AHQR, 2012) Complications are costly both financially and in terms of morbidity such as lower extremity amputation, retinopathy/blindness, and renal failure, all preventable with early and effective treatment. The National Committee on Quality Assurance (NCQA, expert consensus **evidence**) and the Healthcare Effectiveness Data & information Set (HEDIS) 2012 recommend periodic retinal eye exams among those 18 to 75 years of age with Type I or Type II Diabetes. Further, **evidence** of higher rates of chronic disease prevalence in **Region 1** (including Diabetes morbidity) supports the selection of this particular measure and is likely to **focus** the application of specialty care in a manner which will **improve health outcomes of the lower income populations** served by UPA. For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: Rural underserved populations continue to carry the heaviest burden of both a primary care workforce and specialist shortage. Infrastructure investment in this project is intended to improve access to specialty care within the UTHSCT/UPA network of clinics and patient population (Smith, Upshur, and Rusk Counties) as well as collaborate with the GSMC IMR. Assessment of the gaps in specialty services and implementation of a plan to increase targeted specialty access will help to create an efficient referral system which will result in timely care. Use of a Category 3, evidence-based outcome measures which relies upon specialty care services such as ophthalmologic exams is intended to improve quality of care. Taken together, these benefits will help to reduce the financial burden to the regional health care system through early detection and management of disease, reduced morbidity, and reduced utilization of high costs services. The value of this project is justifiable on the basis of:

- Addressing CN.1, insufficient access to primary and specialty health care, by enhancing access to specialty care services for a rural/vulnerable population and to promote early intervention measures.
- Improved coordination of care resulting in more timely delivery and better compliance with recommended improvement targets.
- Building capacity and sustainability through process development, recruitment of specialty services, and training residents in appropriate specialty referral procedures.

References:

Agency for Healthcare Research and Quality (AHRQ), National Quality Measures Clearinghouse. Comprehensive diabetes care, HEDIS 2012. Available at: http://www.qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?orgid=8&objid=34614 (last accessed 10-06-2012).

127278302.3.32 Pass 3b (127278302.3.2)	*3.IT-1.12*	Diabetes care: *Retinal eye exam*	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	*127278302.1.9 Pass 3b (127278302.1.2)*		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gaps in specialty care Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $39,254 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $40,383 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $40,383	**Outcome Improvement Target 1** IT-1.12: Diabetes care: *Retinal eye exam* Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $168,442	**Outcome Improvement Target 2** IT-1.12: Diabetes care: *Retinal eye exam* Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $469,225
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $39,254	Year 3 Estimated Outcome Amount: $80,766	Year 4 Estimated Outcome Amount: $168,442	Year 5 Estimated Outcome Amount: $469,225
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $757,687			

Outcome Measure (Improvement Target) IT-1.13 Diabetes care: *Foot exam*
Unique RHP Outcome Identification Number: 127278302.3.33 Pass 3b (127278302.3.3)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Process outcomes selected for DY2 and DY3 are directly related to initial components of this initiative. Improving access to specialty care will be achieved through a series of steps to incorporate **core project components** as specified in Category 1 of the RHP Planning Protocol (Texas Health and Human Services Commission, 2012) as follows:

- Confirm specialty care **gaps** early. Targeted specialties of interest for consideration include ophthalmology, podiatry, nephrology, endocrinology/diabetes care, neurology/pain, infectious diseases, dermatology, and rheumatology
- Develop/implement a specialty care access **plan** which addresses targeted gaps in specialty care for this network of clinics as well as potential referrals from Good Shepherd Medical Center (GSMC) Internal Medicine Residency (IMR)
- Recruit or negotiate arrangements to fill these gaps within the UPA patient care network of clinics
- **Train/educate** healthcare team professionals on processes, guidelines, and technology which will optimize timely referrals to and consultations by selected medical specialties
- Increase service availability and specialty clinic locations
- Implement coordinated referrals across the network of clinics
- Conduct **quality improvement** activities to identify barriers to timely referral consultation, e.g., Plan-Do-Study-Act (PDSA)

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Chronic Disease Management (OD-1). For this unique Category 3 outcome measure, this will include Diabetes care: *Foot exam* (IT-1.13). As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States, frequently undiagnosed. (AHQR, 2012) Complications are costly both financially and in terms of morbidity such as lower extremity amputation, retinopathy/blindness, and renal failure, all preventable with early and effective treatment. The National Committee on Quality Assurance (NCQA, expert consensus **evidence**) and the Healthcare Effectiveness Data & information Set (HEDIS) 2012 recommend periodic specialty exams among those 18 to 75 years of age with Type I or Type II Diabetes, in this instance, a foot exam by a podiatrist. Further, **evidence** of higher rates of chronic disease prevalence in **Region 1** (including Diabetes morbidity) supports the selection of this particular measure and is likely to **focus** the application of specialty care in a manner which will **improve health outcomes of the lower income populations** served by UPA. For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: Rural underserved populations continue to carry the heaviest burden of both a primary care workforce and specialist shortage. Infrastructure investment in this project is intended to improve access to specialty care within the UTHSCT/UPA network of clinics and patient population (Smith, Upshur, and Rusk Counties) as well as collaborate with the GSMC IMR. Assessment of the gaps in specialty services and implementation of a plan to increase targeted specialty access will help to create an efficient referral system which will result in timely care. Use of a Category 3, evidence-based outcome measures which relies upon specialty care services such as podiatric examinations is intended to improve quality of care. Taken together, these benefits will help to reduce the financial burden to the regional health care system through early detection and management of disease, reduced morbidity, and reduced utilization of high costs services. The value of this project is justifiable on the basis of:

- Addressing CN.1, insufficient access to primary and specialty health care, by enhancing access to specialty care services for a rural/vulnerable population and to promote early intervention measures.
- Improved coordination of care resulting in more timely delivery and better compliance with recommended improvement targets.
- Building capacity and sustainability through process development, recruitment of specialty services, and training residents in appropriate specialty referral procedures.

References:

Agency for Healthcare Research and Quality (AHRQ), National Quality Measures Clearinghouse. Comprehensive diabetes care, HEDIS 2012. Available at: http://www.qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?orgid=8&objid=34614 (last accessed 10-06-2012).

127278302.3.33 Pass 3b (127278302.3.3)	*3.IT-1.13*	Diabetes care: *Foot exam*	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	*127278302.1.9 Pass 3b (127278302.1.2)*		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gaps in specialty care Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $39,254 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $40,383 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $40,383	**Outcome Improvement Target 1** IT-1.13: Diabetes care: Foot *exam* Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $168,442	**Outcome Improvement Target 2** IT-1.13: Diabetes care: Foot *exam* Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $469,225
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $39,254	Year 3 Estimated Outcome Amount: $80,766	Year 4 Estimated Outcome Amount: $168,442	Year 5 Estimated Outcome Amount: $469,225
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $757,687			

Outcome Measure (Improvement Target): IT-1.14 Diabetes care: *Microalbumin/Nephropathy* **-**
Unique RHP Outcome Identification Number: 127278302.3.34 Pass 3b (127278302.3.4)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Process outcomes selected for DY2 and DY3 are directly related to initial components of this initiative. Improving access to specialty care will be achieved through a series of steps to incorporate **core project components** as specified in Category 1 of the RHP Planning Protocol (Texas Health and Human Services Commission, 2012) as follows:

- Confirm specialty care **gaps** early. Targeted specialties of interest for consideration include ophthalmology, podiatry, nephrology, endocrinology/ diabetes care, neurology/pain, infectious diseases, dermatology, and rheumatology
- Develop/implement a specialty care access **plan** which addresses targeted gaps in specialty care for this network of clinics as well as potential referrals from Good Shepherd Medical Center (GSMC) Internal Medicine Residency (IMR)
- Recruit or negotiate arrangements to fill these gaps within the UPA patient care network of clinics
- **Train/educate** healthcare team professionals on processes, guidelines, and technology which will optimize timely referrals to and consultations by selected medical specialties
- Increase service availability and specialty clinic locations
- Implement coordinated referrals across the network of clinics
- Conduct **quality improvement** activities to identify barriers to timely referral consultation, e.g., Plan-Do-Study-Act (PDSA)

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Chronic Disease Management (OD-1). For this unique Category 3 outcome measure, this will include Diabetes care: *Microalbumin/Nephropathy* (IT-1.14). As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States, frequently undiagnosed. (AHQR, 2012) Complications are costly both financially and in terms of morbidity such as lower extremity amputation, retinopathy/blindness, and renal failure, all preventable with early and effective treatment. The National Committee on Quality Assurance (NCQA, expert consensus **evidence**) and the Healthcare Effectiveness Data & information Set (HEDIS) 2012 recommend a periodic screening test for nephropathy among those 18 to 75 years of age with Type I or Type II Diabetes. Further, **evidence** of higher rates of chronic disease prevalence in **Region 1** (including Diabetes morbidity) supports the selection of this particular measure and is likely to **focus** the application of specialty care in a manner which will **improve health outcomes of the lower income populations** served by UPA. For this initial plan submission, as a non-hospital performing provider, the

associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: Rural underserved populations continue to carry the heaviest burden of both a primary care workforce and specialist shortage. Infrastructure investment in this project is intended to improve access to specialty care within the UTHSCT/UPA network of clinics and patient population (Smith, Upshur, and Rusk Counties) as well as collaborate with the GSMC IMR. Assessment of the gaps in specialty services and implementation of a plan to increase targeted specialty access will help to create an efficient referral system which will result in timely care. Use of a Category 3, evidence-based outcome measures which relies upon specialty care services such as nephrology screening is intended to improve quality of care. Taken together, these benefits will help to reduce the financial burden to the regional health care system through early detection and management of disease, reduced morbidity, and reduced utilization of high costs services. The value of this project is justifiable on the basis of:

- Addressing CN.1, insufficient access to primary and specialty health care, by enhancing access to specialty care services for a rural/vulnerable population and to promote early intervention measures.
- Improved coordination of care resulting in more timely delivery and better compliance with recommended improvement targets.
- Building capacity and sustainability through process development, recruitment of specialty services, and training residents in appropriate specialty referral procedures.

References:

Agency for Healthcare Research and Quality (AHRQ), National Quality Measures Clearinghouse. Comprehensive diabetes care, HEDIS 2012. Available at: http://www.qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?orgid=8&objid=34614 (last accessed 10-06-2012).

127278302.3.34 Pass 3b (127278302.3.4)	*3.IT-1.14*	Diabetes care: *Microalbumin/Nephropathy*	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	*127278302.1.9 Pass 3b (127278302.1.2)*		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gaps in specialty care Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $39,254 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $40,383 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $40,383	**Outcome Improvement Target 1** IT-1.14: Diabetes care: *Microalbumin/Nephropathy* Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $168,442	**Outcome Improvement Target 2** IT-1.14: Diabetes care: *Microalbumin/Nephropathy* Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $469,225
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $39,254	Year 3 Estimated Outcome Amount: $80,766	Year 4 Estimated Outcome Amount: $168,442	Year 5 Estimated Outcome Amount: $469,225
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $757,687			

Outcome Measure (Improvement Target) IT-9.1 – Decrease in mental health admissions and readmissions to criminal justice settings such as jails, or prisons
Unique RHP Outcome Identification Number: 127278302.3.35 Pass 3b (127278302.3.5)
Performing Provider: UTHSCT – MSRDP University Physician Associates) 127278302

Outcome Measure Description: Process outcomes selected for DY2 and DY3 are directly related to initial components of this initiative. Implementing technology-assisted services to support and coordinate behavioral health services will be achieved through a series of steps to incorporate **core project components** as specified in Category 1 of the RHP Planning Protocol (Texas HHSC, 2012) as follows:

- Assess the existing infrastructure for **high speed broadband communications technology** and the local availability/need for video communication equipment, and develop a **plan** for enhancing and adapting the current telehealth/tele-education network for delivery of telemental services
- Develop or adapt protocols to deal with matters such as medical records, privacy, credentialing, and scheduling
- **Train** qualified behavioral health providers, resident physicians, and other relevant participants on processes, guidelines, and technology which will optimize use of the network
- Track encounters to establish a baseline and collect data to assess intermediate outcomes relative to access
- Conduct **quality improvement** activities such as Plan-Do-Study-Act (PDSA)
- Extend a telemental connection between provider and criminal justice systems to promote right care in the right setting; assess impact on patient experience outcomes

Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to assess existing infrastructure, develop protocols and train personnel as outlined above. These include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, a single standalone measure is selected from the domain Right Care, Right Setting (OD-9). Specifically, this will be IT-9.1, Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: Evidence suggests that "interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning." (Texas HHSC, 2012, p. 405) This project will add a unique component to management of behavioral crises patients by facilitating combined medical as well as societal evaluation of individuals when questions of management location arise. The proposed network will extend a telemental connection between provider and criminal justice systems so that such determinations might be made more appropriately, readily, and efficiently and when a direct interaction is necessary prior to patient transportation. The ultimate **focus** of this intervention in **Region 1** is to **improve health outcomes of the lower income populations** that are disproportionately affected. For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: East Texas experiences high levels of behavioral health morbidity and the rural uninsured populations remain disproportionately affected. There continues to be limited access to behavioral health services for poor and vulnerable groups in this region. Cycling through criminal justice systems is often tied to poor mental health outcomes and high costs to society. This project is intended to expand and enhance the infrastructure necessary to build targeted telemental/telehealth capacity within the Northeast Texas region, spanning multiple rural counties, and partnering with their respective healthcare providers. Modern communications technology is felt to hold considerable promise for filling gaps in access for behavioral healthcare delivery. Following an assessment of existent infrastructure, a plan will be devised for enhancing technical capabilities and connectivity, and implementing protocols, training, and quality improvement methods for effective delivery of care services. Use of Category 3, evidence-based measures will demonstrate improvement in outcomes tied to Right Care in the Right Setting. This infrastructure investment will help to reduce the financial burden to the regional health care system through provision of care in the appropriate setting and reduced utilization of high cost services such as emergency department visits and unnecessary hospitalization. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing CN.2, insufficient access to mental and behavioral health services.
- Enhanced access to behavioral health services for a rural/vulnerable population.
- Developing infrastructure which can increase access to high quality care.
- Building capacity through training of multiple providers and other related participants (CHWs) in the delivery and facilitation of telemental interactions.
- Providing a platform for integration of primary care and behavioral health as well as training for primary care residents.
- Reducing behavioral health morbidity resulting from cycling through the criminal justice system by providing Right Care in the Right Setting.
- Engagement of multiple large stakeholders in collaborative service delivery in Region 1.

References:

Texas Health and Human Services Commission (HHSC). Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

127278302.3.35 Pass 3b (127278302.3.5)	*3.IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	*127278302.1.10 Pass 3b (127278302.1.3)*		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation and assessment of capabilities, equipment, issues, plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $82,263	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $47,100 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $47,100	**Outcome Improvement Target 1** IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $150,327	**Outcome Improvement Target 2** IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $334,018
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $82,263	Year 3 Estimated Outcome Amount: $94,200	Year 4 Estimated Outcome Amount: $150,327	Year 5 Estimated Outcome Amount: $334,018
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $660,808			

Outcome Measure (Improvement Target) ~~**IT-9.4:**~~ **IT-1.11:** ~~"Other" - Increase the number of DSHS certified CHWs working in chronic or behavioral health in Region 1~~ Diabetes Care: BP Control – Increase BP compliance among diabetic patients whom are 18 to 75 years of age with diabetes
Unique RHP Outcome Identification Number - 127278302.3.6
Performing Provider/TPI : UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: DY 2 is comprised of two process milestones. The first process milestone is **P-1 Project Planning** which will consist of engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. The second process milestone is **P-2 Establishing Baseline Rates** in which the CHW program administration will work to establish and then report baseline numbers of the **number of CHWs who achieve DSHS certification**, and become employed in **chronic health and/or behavioral health** in **Region 1.**

DY 3 is comprised of one process milestone and one outcome improvement target. The process milestone is **P-3**, the **development** and **testing of data systems** that will hold data and help with reporting of CHW certification and employment status. The outcome improvement target, ~~**IT-9.4**, will measure the CHW graduates **DSHS certification rate** and **employment status** compared to **baseline** established in DY 2 among current CHWs residing in Region 1.~~ **IT-1.11**, which will strive to **control BP (<140/80mm Hg)** among **diabetic** and high risk UTHSCT CHW patients residing in region 1; with a goal of BP compliance among patients 18 to 75 years of age whom as of the end of the measurement year has been diagnosed with diabetes or whom are at high risk for diabetes. Percentage of increase of compliance will be determined following the establishment of baseline rates in DY 2.

DY 4 is comprised of a single outcome improvement target, ~~**IT-9.4, which will measure the CHW graduates DSHS certification rate and employment status compared to baseline established in DY 2 among current CHWs residing in Region 1.**~~ **IT-1.11**, which will strive to **control BP (<140/80mm Hg)** among **diabetic** and high risk UTHSCT CHW patients residing in region 1; with a goal of BP compliance among patients 18 to 75 years of age whom as of the end of the measurement year has been diagnosed with diabetes or whom are at high risk for diabetes. Percentage of increase of compliance will be determined following the establishment of baseline rates in DY 2.

DY 5 is comprised of a single outcome improvement target, ~~**IT-9.4, which will measure the CHW graduates' DSHS certification rate and employment status compared to baseline established in DY 2 among current CHWs residing in Region 1.**~~ **IT-1.11**, which will strive to **control BP (<140/80mm Hg)** among **diabetic** and high risk UTHSCT CHW patients residing in region 1; with a goal of BP compliance among patients 18 to 75 years of age whom as of the end of the measurement year has been diagnosed with diabetes or whom are at high risk for diabetes. Percentage of increase of compliance will be determined following the establishment of baseline rates in DY 2.

Rationale: The region has a higher than average prevalence of certain chronic diseases, and **admission rates for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF),** and mortality rates from **heart disease** and **chronic lung disease** are among the highest in the state. The majority of counties in Northeast Texas also have higher rates of **preventable hospitalizations for pneumonia, congestive heart failure, high blood pressure, asthma, COPD, and diabetes** compared to the rates for Texas. Further, it was also estimated that over 85,000 individuals regionally have a serious **mental illness**, with well over 100,000 needing treatment for **alcohol/drug** use. Prior research has shown that CHWs are effective in increasing knowledge and promoting behavior change, increasing improvement in utilization patterns, and **reducing ER visits**, **hospital admissions/readmissions** and total **patient costs**. By implementing the category 1 project- Increasing Training of the Primary Care Workforce; the category 3 metrics of increasing the number of DSHS certified CHWs working in chronic or behavioral health in Region 1 and increasing BP compliance among diabetic patients can be achieved. Specific percentage change anticipated by the implementation of the CHW program will be added to outcome improvement targets in DY3, 4, and 5 following DY 2 establishment of **baseline** data.

Outcome Measure Valuation: Rural underserved populations continue to carry the heaviest burden of both a primary care workforce and specialist shortage. Infrastructure investment in this project is intended to improve access to primary and specialty care within Region 1. Assessment of the gaps in primary care and specialty services and implementation of a plan to increase targeted primary and specialty access will help to create an efficient access to a care system which will result in the right care in the right setting. Use of Category 3, evidence-based outcome measures which rely upon the increase in primary care workforce; specifically the CHW; are intended to improve access to care and ensure appropriate care utilization. Taken together, these benefits will help to reduce the financial burden to the regional health care system through early detection and management of disease, reduced morbidity, and reduced utilization of high cost services. The value of this project is justifiable on the basis of:

- Addressing CN.1, insufficient access to primary and specialty health care, by enhancing access to primary care and specialty care services for a rural/vulnerable population and to promote early intervention measures.
- Improved coordination of care resulting in more timely delivery and better compliance with recommended improvement targets.
- Building capacity and sustainability through process development, training and recruitment of CHWs, and training of CHWs in appropriate referral procedures and chronic and behavioral health interventions.

127278302.3.6	*3.IT-~~9.4~~ 1.11*	*~~"Other" – Increase~~ ~~the number of DSHS certified CHW's working in chronic or behavioral health in Region 1~~* Diabetes Care: BP Control	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.1.4		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Project Planning – P-1: Data Source: Engage Stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 26,573 **Process Milestone 2** Establish Baseline Rates - P-2: Data Source: Report Baseline Numbers Process Milestone 2 Estimated Incentive Payment: $ 26,573	**Process Milestone 3** Develop and Test Data Systems - P-3 Data Source: Document and Implement Data Systems Process Milestone 3 Estimated Incentive Payment: $ 139,709 ~~**Outcome Improvement Target 1** IT-9.4: Improvement Target: Increase the number of CHW's DSHS Certified and working in chronic or behavioral health in Region 1~~ **Outcome Improvement Target 1** IT-1.11: Improvement Target: Increase BP compliance among UTHSCT CHW patients 18 to 75 years of age whom has been diagnosed with diabetes or whom are at high risk for diabetes. Data Source: CHW records and Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $139,709	~~**Outcome Improvement Target 2** IT-9.4:~~ ~~Improvement Target: Increase the number of CHW's DSHS Certified and working in chronic or behavioral health in Region 1~~ **Outcome Improvement Target 2** IT-1.11: Improvement Target: Increase BP compliance among UTHSCT CHW patients 18 to 75 years of age whom has been diagnosed with diabetes or whom are at high risk for diabetes. Data Source: CHW records and survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 265,319	~~**Outcome Improvement Target 3** IT-9.4:~~ ~~Improvement Target: Increase the number of CHW's DSHS Certified and working in chronic or behavioral health in Region 1~~ **Outcome Improvement Target 3** IT-1.11: Improvement Target: Increase BP compliance among UTHSCT CHW patients 18 to 75 years of age whom has been diagnosed with diabetes or whom are at high risk for diabetes. Data Source: CHW records and survey Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 397,979
Year 2 Estimated Outcome Amount: $ 53,146	Year 3 Estimated Outcome Amount: $ 279,419	Year 4 Estimated Outcome Amount: $ 265,319	Year 5 Estimated Outcome Amount: $397,979
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 995,863			

Outcome Measure (Improvement Target) : IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate **RH**
Unique RHP Outcome Identification Number: 127278302.3.36 Pass 3b (127278302.3.7)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Reduce ambulatory sensitive conditions admission rate by 7.5% from baseline by the end of year 5. CSM will establish the baseline ambulatory sensitive condition rate during year 2. During year 3 CSM plans to reduce the ambulatory sensitive conditions admission rate by 2.5% from the baseline established in year 2. During year 4 CSM plans to reduce the ambulatory sensitive conditions admission rate by 5% from the baseline established in year 2. During year 5 CSM plans to reduce the ambulatory sensitive conditions admission rate by 7.5% from the baseline established in DY2.
Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care.
Outcome Measure Valuation: According to a 2006 by Joanna Jiang Ph.D[59], hospital costs for potentially preventable conditions totaled nearly $30.8 billion—one of every 10 dollars of total hospital expenditures. As many as 4.4 million hospital stays could possibly have been prevented with better ambulatory care, improved access to effective treatment, or patient adoption of healthy behaviors. The implementation and management of this project will have a direct impact reducing these types of admissions which many times have a point of entry to the health system through the emergency department, a very expensive care center.

[59] Nationwide Frequency and Costs of Potentially Preventable Hospitalizations, 2006 Jiang Ph.D, H. Joanna http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp

127278302.3.36 Pass 3b (127278302.3.7)	3.IT-2.11	Ambulatory Care Sensitive Conditions Admissions Rate	
UPA			127278302
Related Category 1 or 2 Projects::	127278302.1.11 Pass 3b (127278302.1.5)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: EHR, Claims **Process Milestone 1** Estimated Incentive Payment (maximum amount): $77,747	**Outcome Improvement Target 1** IT-2.11: Reduce ambulatory sensitive conditions admission rate. **Improvement Target**: Reduce ambulatory sensitive condition admission rate by 2.5% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 1** Estimated Incentive Payment: $314,445	**Outcome Improvement Target 2** IT-2.11: Reduce ambulatory sensitive conditions admission rate. Improvement Target: Reduce ambulatory sensitive condition admission rate by 5.0% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 2** Estimated Incentive Payment: $391,374	**Outcome Improvement Target 3** [IT-2.11]:Reduce ambulatory sensitive conditions admission rate. Reduce ambulatory sensitive conditions admission rate. Improvement Target: Reduce ambulatory sensitive condition admission rate by 7.5% from baseline. Data Source: EHR, Claims Outcome Improvement Target 3 Estimated Incentive Payment: $754,592
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $77,747	Year 3 Estimated Outcome Amount: $314,445	Year 4 Estimated Outcome Amount: $391,374	Year 5 Estimated Outcome Amount: $754,592
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $1,538,158			

Outcome Measure (Improvement Target): IT 7.10 Other Outcome Improvement Target (Decrease the percentage of non-emergent emergency department visits for dental care)

Unique RHP Outcome Identification Number: 127278302.3.37 Pass 3b (127278302.3.8)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Decrease the percentage of patients accessing the emergency department for dental care by 10% (which would be classified as in levels 1 & 2 visits) from baseline by the end of year 5. CSM will establish the baseline percentage of emergency department visits for dental care during year 2. During year 3 CSM plans to decrease the percentage emergency department visits for dental care by 3% from the baseline established in year 2. During year 4 CSM plans to decrease the percentage emergency department visits for dental care by 6.5% from the baseline established in year 2. During year 5 CSM plans to decrease the percentage emergency department visits for dental care by 10% from the baseline established in year 2.

Rationale: States can reduce or contain dental costs in the emergency department setting by making better use of proven forms of prevention, improving access by expanding the number of dental practitioners. When so many people seek care at hospitals for preventable dental problems, it wastes taxpayer dollars. Investing more in prevention and ensuring access to treatment could save money by reducing the incidence of untreated decay and other dental ailments.[60] Because of the high number of dental cases, 698 in levels 1 and 2, the organization treated in the emergency department during SFY12, CSM felt this would be an appropriate measure to track success of the newly established clinic for the targeted patient population.

Outcome Measure Valuation: This outcome measure derives its value as a result of the reduction of inappropriate use of the ED for dental health care, improved dental health outcomes via preventive and remedial services to the at risk population, and reduce expense for dental health care. This measure is aligned with the community needs of the RHP (CN.1, CN.4, and CN.5) and its regional goal to reduce the costs of health care.

[60] (PEW Children's Dental Campaign, The PEW Center on The States, February 2012. *www.pewcenteronthestates.org/dental*)

127278302.3.37 Pass 3b (127278302.3.8)	*3.IT-7.10*	*Decrease the percentage non-emergent emergency department visits for dental care*	
UPA			*127278302*
Related Category 1 or 2 Projects::	*127278302.1.12 Pass 3b (127278302.1.6)*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1– P-2: Establish baseline percentage of visits to the emergency department for dental care. Data Source: EHR, Claims Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $73,766	**Outcome Improvement Target 1** [IT-7.10]: Decrease the percentage emergency department visits for dental care by 3% from baseline. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* *$ 298,344*	**Outcome Improvement Target 2** [IT-7.10]: Decrease the percentage emergency department visits for dental care by 6.5% from baseline. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* *$371,334*	**Outcome Improvement Target 3** [IT-7.10]: Decrease the percentage emergency department visits for dental care by 10% from baseline. Data Source: EHR, Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $715,953
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,766	Year 3 Estimated Outcome Amount: $298,344	Year 4 Estimated Outcome Amount: $371,334	Year 5 Estimated Outcome Amount: $715,953
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,459,397			

Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 127278302.3.38 Pass 3b (127278302.3.9)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: This outcome measure will focus on reducing ED utilization for behavioral Health. DY2 will involve a process measure for establishing the baseline rate and DY3-5 will focus on improvements. ~~Improvement targets for DY3-5 will be set once the baseline is established.~~ The crisis stabilization unit will allow behavioral health patients that are medically stable (no acute care issues) to bypass the emergency department and/or admission to acute care settings (e.g. Intensive Care Units) and be placed in a secure/safe environment for evaluation for appropriate treatment.

Rationale: The primary goal of this outcome measure is to achieve a more appropriate utilization of the ED by reducing the number of services that would have more appropriately been delivered at an alternate site of care. The ED appropriate Utilization improvement target will measure the true impact the linked crisis stabilization project is having on ED utilization. ~~As stated above, improvement targets will be implemented in DY3-5.~~ As a demonstration project, our goal is to reduce emergency room visits for behavioral health patients. Based on our recent emergency department activity with behavioral health inpatient admissions, we expect to reduce ER visits for behavioral health patients by 240 patient visits in DY3 with additional decrease by 5% in DY4 and 10% in DY5 compared with DY3 baseline.

Outcome Measure Valuation: In valuing this project, UPA and its collaborative partner, Palestine Regional Medical Center, took into account the extent to which the implementation of a crisis stabilization center would provide cost avoidance with reduced emergency department costs by placing behavioral health crisis patients into a safe environment outside the ED while awaiting appropriate treatment options. This placement of patients outside of the ED will allow for increased bed availability for acute care patients requiring right care at the right time thus increasing revenue potential. In addition to excessive ED costs, patients also incur costs for being admitted to inpatient facilities and/or jail. Providing patients the option of crisis stabilization will reduce premature placement into inpatient services and save county judicial and law enforcement organizations costs by reducing unnecessary oversight in ED requirements and/or incarceration. By ensuring appropriate ED utilization, PRMC can ensure that the limited healthcare resources of the community are used more efficiently and help slow the rise of healthcare costs as a result of their inefficient use.

127278302.3.38 Pass 3b (127278302.3.9)	3.IT-9.2	ED Appropriate Utilization	
	UPA		127278302
Related Category 1 or 2 Projects::	127278302.1.13 Pass 3b (127278302.1.7)		
Starting Point/Baseline:	Baseline to be established in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Reports demonstrating number of behavioral health patients current receiving treatment in appropriate setting Process Milestone 1 Estimated Incentive Payment *(maximum amount):* **$**38,733	**Outcome Improvement Target 1** IT-9.2: ED Appropriate Utilization Improvement Target: ~~**TBD**~~ Project to reduce ER visits for behavioral health patients by 240 patient visits Data Source: Abstracts data from patient records Outcome Improvement Target 1 Estimated Incentive Payment*:* **$**94,519	**Outcome Improvement Target 2 1**IT-9.2: ED Appropriate Utilization Improvement Target: ~~**TBD**~~ 5% **of DY3 projected baseline** Data Source: Abstracts data from patient records Outcome Improvement Target 2 Estimated Incentive Payment*:* **$**151,671	**Outcome Improvement Target 3 1**IT-9.2: ED Improvement Target: ~~**TBD**~~ 10% **of DY3 projected baseline** Data Source: Abstracts data from patient records Outcome Improvement Target 3 Estimated Incentive Payment*:* **$362,690**
Year 2 Estimated Outcome Amount: **$ 38,733**	Year 3 Estimated Outcome Amount: **$**94,519	Year 4 Estimated Outcome Amount: **$**151,671	Year 5 Estimated Outcome Amount: **$362,690**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* **$** 647,613			

Outcome Measure (Improvement Target): IT-12.~~3~~ 1 – ~~Colorectal~~ Breast Cancer Screening
Unique RHP Outcome Identification Number: 127278302.3.10
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition. This initiative will undertake a series of steps which incorporate **core project components** (2.1.1.a-d) to achieve NCQA recognition for the UPA clinics identified in this proposal as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). For this unique Category 3 outcome measure, this will include ~~colorectal~~ breast cancer screening (IT-12.~~3~~1). As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as ~~colorectal~~ breast cancer screening. Further, evidence of higher rates of selective cancer incidence in **Region 1** supports the selection of this particular measure and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by these clinics. Early detection screening tests will be selected with the objective "to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective," thereby reducing disease burden. (Texas Health and Human Services Commission). Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012.) Mammography guidelines such as those of the U.S. Preventive Services Task Force or USPSTF will be considered for this project. (USPSTF). USPSTF A and B recommendations, 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last accessed 02-21-2013). For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a series of clinics within a busy academic health science center as well as to rurally based satellite clinics in the region (Smith, Upshur, and Rusk Counties). This is particularly true where there has been little assessment of current practice capabilities, where there are few personnel resources, and where training in systems engineering initiatives have been limited. Yet, it is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as ~~colorectal~~ breast cancer screening, thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. This Category 3 outcome measure is selected to demonstrate the benefit of implementing the medical home model in this setting. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.
- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development.

127278302.3.10	*3.IT-12.~~3~~1*	*~~Colorectal~~ Breast Cancer Screening*	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	*127278302.2.1*		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gap analysis Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $36,437 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $37,481 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $37,481	**Outcome Improvement Target 1** IT-12.~~3~~1: ~~Colorectal~~ Breast Cancer Screening Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $154,228	**Outcome Improvement Target 1** IT-12.~~3~~1: ~~Colorectal~~ Breast Cancer Screening Improvement Target: x%(TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $269,724
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,437	Year 3 Estimated Outcome Amount: $74,962	Year 4 Estimated Outcome Amount: $154,228	Year 5 Estimated Outcome Amount: $269,724
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $535,351			

Outcome Measure (Improvement Target): IT – 12.4 - Pneumonia vaccination status for older adults
Unique RHP Outcome Identification Number: 127278302.3.11
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition. This initiative will undertake a series of steps which incorporate **core project components** (2.1.1.a-d) to achieve NCQA recognition for the UPA clinics identified in this proposal as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). For this unique Category 3 outcome measure, this will include pneumonia vaccination status for older adults (IT-12.4). As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as pneumonia vaccination status for older adults. Further, evidence of higher rates of chronic disease prevalence (such as chronic respiratory disease) and smoking in **Region 1** supports the selection of this particular measure and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by these clinics. (See CDC website http://www.cdc.gov/vaccines/vpd-vac/pneumo/default.htm#vacc .) For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a series of clinics within a busy academic health science center as well as to rurally based satellite clinics in the region (Smith, Upshur, and Rusk Counties). This is particularly true where there has been little assessment of current practice capabilities, where there are few personnel resources, and where training in systems engineering initiatives have been limited. Yet, it is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care,

enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as pneumonia vaccination, thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. This Category 3 outcome measure is selected to demonstrate the benefit of implementing the medical home model in this setting. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.
- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development.

127278302.3.11	3.IT-12.4	Pneumonia vaccination status for older adults	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.1		
Starting Point/Baseline:	TBD by DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gap analysis Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $36,437 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $37,481 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $37,481	**Outcome Improvement Target 1** IT-12.4: Pneumonia vaccination status for older adults Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $154,228	**Outcome Improvement Target 2** IT-12.4: Pneumonia vaccination status for older adults Improvement Target: x%(TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $269,724
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,437	Year 3 Estimated Outcome Amount: $74,962	Year 4 Estimated Outcome Amount: $154,228	Year 5 Estimated Outcome Amount: $269,724
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $535,351			

Outcome Measure (Improvement Target) : IT-12.5 Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening)

Unique RHP Outcome Identification Number: 127278302.3.12
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition. This initiative will undertake a series of steps which incorporate **core project components** (2.1.1.a-d) to achieve NCQA recognition for the UPA clinics identified in this proposal as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). For this unique Category 3 outcome measure, this will include a United States Preventive Services Task Force (USPSTF)-endorsed measure (IT-12.5, cholesterol abnormalities screening) as ~~determined~~ confirmed by the provider along with initial gap analysis and project planning. As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as USPSTF-endorsed screening outcome measures. Further, evidence of higher rates of chronic disease prevalence and selective cancer incidence in **Region 1** support the selection of ~~such~~ a measure such as cholesterol abnormalities screening to be ~~identified~~ confirmed in a clinical gap analysis and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by these clinics. The USPSTF is an independent group of national experts that makes evidence-based recommendations about clinical preventive services such as screening. (See USPSTF web site at http://www.ahrq.gov/clinic/uspstfix.htm.) "Screening for a disease implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a group of apparently healthy people to identify those having unrecognized disease. People with positive screening tests are subsequently investigated with diagnostic tests and those with

confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from the disease by detecting early preclinical disease when treatment may be easier and more effective than for advanced disease," thereby reducing morbidity and potentially, mortality. (Texas Health and Human Services Commission. Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012.)) The USPSTF offers evidence-based recommendations for selective forms of screening. For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a series of clinics within a busy academic health science center as well as to rurally based satellite clinics in the region (Smith, Upshur, and Rusk Counties). This is particularly true where there has been little assessment of current practice capabilities, where there are few personnel resources, and where training in systems engineering initiatives have been limited. Yet, it is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as USPSTF endorsed measures, in this instance, cholesterol abnormalities screening, thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. This Category 3 outcome measure is selected to demonstrate the benefit of implementing the medical home model in this setting. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.
- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development.

127278302.3.12	3.IT-12.5	Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.1		
Starting Point/Baseline:	TBD by DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gap analysis Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $36,437 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $37,481 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $37,481	**Outcome Improvement Target 1** IT-12.5: Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening) Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $154,228	**Outcome Improvement Target 2** IT-12.5: Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening) Improvement Target: x%(TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $269,724
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,437	Year 3 Estimated Outcome Amount: $74,962	Year 4 Estimated Outcome Amount: $154,228	Year 5 Estimated Outcome Amount: $269,724
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $535,351			

Outcome Measure (Improvement Target): IT 12.3 - Colorectal Cancer Screening

Unique RHP Outcome Identification Number: 127278302.3.39 Pass 3b (127278302.3.13)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition. This initiative will undertake a series of steps which incorporate **core project components** (2.1.1.a-d) to achieve NCQA recognition for the Good Shepherd Medical Center Internal Medicine Residency (IMR) clinic identified in this proposal as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Adopt the Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). For this unique Category 3 outcome measure, this will include colorectal cancer screening (IT-12.3). As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as colorectal cancer screening. Further, evidence of higher rates of selective cancer incidence in **Region 1** supports the selection of this particular measure and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by the IMR. Early detection screening tests will be selected with the objective "to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective," thereby reducing disease burden. (Texas Health and Human Services Commission. Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012.)) For this initial plan submission, as

a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a new IMR continuity clinic which serves a vulnerable rural population. It is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as colorectal cancer screening, thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.
- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development and residency education.

127278302.3.39 Pass 3b (127278302.3.13)	3.IT-12.3	Colorectal Cancer Screening	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.14 Pass 3b (127278302.2.2)		
Starting Point/Baseline:	TBD by DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gap analysis Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $38,970 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $34,041.50 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $34,041.50	**Outcome Improvement Target 1** IT-12.3: Colorectal Cancer Screening Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $141,476	**Outcome Improvement Target 2** IT-12.3: Colorectal Cancer Screening Improvement Target: x%(TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $273,071
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $38,970	Year 3 Estimated Outcome Amount: $68,083	Year 4 Estimated Outcome Amount: $141,476	Year 5 Estimated Outcome Amount: $273,071
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $521,600			

Outcome Measure (Improvement Target) IT – 12.4 - Pneumonia vaccination status for older adults

Unique RHP Outcome Identification Number: 127278302.3.40 Pass 3b (127278302.3.14)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition. This initiative will undertake a series of steps which incorporate **core project components** (2.1.1.a-d) to achieve NCQA recognition for the Good Shepherd Medical Center Internal Medicine Residency (IMR) clinic identified in this proposal as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Adopt the Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). For this unique Category 3 outcome measure, this will include pneumonia vaccination status for older adults (IT-12.4). As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as pneumonia vaccination status for older adults. Further, evidence of higher rates of chronic disease prevalence (such as chronic respiratory disease) and smoking in **Region 1** supports the selection of this particular measure and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by the IMR. (See CDC website http://www.cdc.gov/vaccines/vpd-vac/pneumo/default.htm#vacc .) For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a new IMR continuity clinic which serves a vulnerable rural population. It is well established

that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as pneumonia vaccination, thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.
- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development and residency education.

127278302.3.40 Pass 3b (127278302.3.14)	*3.IT-12.4*	*Pneumonia vaccination status for older adults*	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	127278302.2.14 Pass 3b (127278302.2.2)		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gap analysis Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $38,970 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $34,041.50 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $34,041.50	**Outcome Improvement Target 1** IT-12.4: Pneumonia vaccination status for older adults Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $141,476	**Outcome Improvement Target 2** IT-12.4: Pneumonia vaccination status for older adults Improvement Target: x%(TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $273,071
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $38,970	Year 3 Estimated Outcome Amount: $68,083	Year 4 Estimated Outcome Amount: $141,476	Year 5 Estimated Outcome Amount: $273,071
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $521,600			

Outcome Measure (Improvement Target): IT-12.5 – Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening)

Unique RHP Outcome Identification Number: 127278302.3.41 Pass 3b (127278302.3.15)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY2 and DY3 are directly related to initial components of the initiative to achieve NCQA recognition. This initiative will undertake a series of steps which incorporate **core project components** (2.1.1.a-d) to achieve NCQA recognition for the Good Shepherd Medical Center Internal Medicine Residency (IMR) clinic identified in this proposal as follows:

- Develop a PCMH recognition team. This team will include primary care physician leaders, a health care administrator with systems engineering experience, patient care navigator, and community health worker(s) (CHWs).
- Perform a PCMH office survey to assess current practice capabilities (**gap analysis**)
- Conduct **educational sessions** for the team and its staff
- Adopt the Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home
- Assess **feasibility** and establish a **project plan** with time frames to **achieve NCQA PCMH recognition**
- Stay organized (binder, file, back-up) and perform periodic assessment of progress (**quality improvement** – Plan-Do-Study-Act (PDSA), identify intermediate outcomes, etc.)
- Engage office staff and providers
- Submit survey and apply to NCQA

Category 3 process outcomes include project planning (P-1), establishing baseline rates (P-2), and conducting a PDSA cycle to improve data collection and intervention activities (P-4) as a quality improvement effort.

In DY4 and DY5, three non-standalone measures are selected from the single domain of Primary Care and Primary Prevention (OD-12). For this unique Category 3 outcome measure, this will include a United States Preventive Services Task Force (USPSTF)-endorsed measure (IT-12.5, cholesterol abnormalities screening) as ~~determined~~ confirmed by the provider along with initial gap analysis and project planning. As a non-hospital performing provider, the associated performance achievement level for this improvement target is to be determined (TBD).

Rationale: NCQA PCMH initiatives support compliance with preventive screenings using **evidence-based** measures such as USPSTF-endorsed screening outcome measures. Further, evidence of higher rates of chronic disease prevalence and selective cancer incidence in **Region 1** support the selection of a measure such as cholesterol abnormalities screening to be ~~identified~~ confirmed in a clinical gap analysis and is likely to **focus** the efforts of the PCMH in a manner which will **improve health outcomes of the lower income populations** served by the IMR. The USPSTF is an independent group of national experts that makes evidence-based recommendations about clinical preventive services such as screening. (See

USPSTF web site at http://www.ahrq.gov/clinic/uspstfix.htm.) "Screening for a disease implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a group of apparently healthy people to identify those having unrecognized disease. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from the disease by detecting early preclinical disease when treatment may be easier and more effective than for advanced disease," thereby reducing morbidity and potentially, mortality. (Texas Health and Human Services Commission. Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012.)) The USPSTF offers evidence-based recommendations for selective forms of screening. For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target for DY4 and DY5 is to be determined (TBD) subsequently (by DY3).

Outcome Measure Valuation: This represents an ambitious project to enhance and expand the PCMH concept to a new IMR continuity clinic which serves a vulnerable rural population. It is well established that the PCMH model is an evidence-based model which uses team-based efforts to provide integrated care, enhance patient and provider experiences, and reduce costly utilization. Investment in leadership development, systems engineering approaches, and coordinated team care has the potential to improve utilization of well recognized preventive services such as USPSTF endorsed measures, in this instance, cholesterol abnormalities screening, thereby reducing morbidity, mortality, and cost associated with advanced disease in Region 1. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing significant regional priority CN.1, insufficient access to primary and specialty health care.
- Enhanced access to integrated primary care services for a rural/vulnerable population and to promote early intervention measures.
- Implementation of a recognized, best-evidence model of care delivery.
- Improved coordination of care resulting in better compliance with preventive measures and population health.
- Building capacity and sustainability through team and process development and residency education.

127278302.3.41 Pass 3b (127278302.3.15)	3.IT-12.5	Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.14 Pass 3b (127278302.2.2)		
Starting Point/Baseline:	TBD by DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Documentation of gap analysis Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $38,970 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 2** P-2: Establish baseline rates Data Source: Registry/EHR Process Milestone 2 Estimated Incentive Payment: $34,041.50 **Process Milestone 3** P-4: Conduct a PDSA cycle to improve data collection Data Source: Registry/EHR Process Milestone 3 Estimated Incentive Payment: $34,041.50	**Outcome Improvement Target 1** IT-12.5: Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening) Improvement Target: x% (TBD) Data Source: Registry/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $141,476	**Outcome Improvement Target 2** IT-12.5: Other USPSTF-endorsed screening outcome measure (cholesterol abnormalities screening) Improvement Target: x%(TBD) Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $273,071
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $38,970	Year 3 Estimated Outcome Amount: $68,083	Year 4 Estimated Outcome Amount: $141,476	Year 5 Estimated Outcome Amount: $273,071
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $521,600			

Outcome Measure (Improvement Target): IT -13.1 – Pain Assessment (NQF-1637)

Unique RHP Outcome Identifier Number – 127278302.3.42 Pass 3b (127278302.3.16)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY 2, DY3, and DY4 are directly related to initial planning processes, education and training activities, and deployment of palliative care and supportive care teams in two separate institutions to demonstrate effective models of care delivery designed to improve quality of care, better outcomes and reduce costs of care.

Process Milestones for this Category 2 project include: P-1 process planning to produce a business plan, P-5 Implementing palliative care for ambulatory patients, P-6 Implementing palliative care for patients during hospitalization using a consultation team.

The Category 2 Improvement milestone for the project is ~~I-11 Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care. The metric is pain management.~~ I-12 Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care with an improvement of scores over time.

Category 3 process milestone include

- P-1 Project planning,
- P-2 establishing baseline for the target population,
- P-5 Disseminate findings to stakeholders.

In DY 4 and DY5 the Outcome Domain is 13 (OD-13) Palliative Care. Three non-standalone measures are selected from the single domain of Palliative Care. These include:

- IT-13.1 Pain assessment
- IT-13.2 Treatment preferences
- IT-5 Per cent of patients receiving palliative care services including a discussion of spiritual/religious concerns.(with chart documentation)

Rationale: Central to the provision of effective palliative care is management of pain (including physical, emotional, and spiritual). The selected outcome measures will be reinforced by charting and data collection that will reinforce delivery of comprehensive palliative care by the teams. Supportive care for people who have debilitating diseases will benefit from supportive care to assist with the myriad advanced planning issues. This will ultimately **improve the quality of care, the quality of life, improve outcomes, and reduce costs.**

Outcome Measure Valuation: The valuation of Category 3 process and outcome measures is predicated on the importance of care, comfort and patient satisfaction above the cost to train and support health care professionals to embrace comfort versus postpone death at all costs. The literature provides ample evidence that palliative care, whether delivered in the hospital, nursing facility, or home, delivered by a multidisciplinary team results in improved quality of

care, increased patient satisfaction, reduction in health care costs, and provider satisfaction. (Brumley; Gore Kaasa ; Morrison ; Morden;). Therefore, the potential benefit and transformation of healthcare delivery derived from adherence to and achievement of the Category 3 metrics will demonstrate that the healthcare providers are functioning effectively as members of a multi-disciplinary team, through training provided in the context of this project and through the learning collaborative, primary care providers will acquire skills with current pain management protocols, and perhaps most significantly, healthcare providers will adopt comfort care as an important and acceptable practice leading to improved quality of life a (Gore, 2012) satisfaction of their patients.

This valuation of this ambitious demonstration project is justified as follows:

- Involves a close collaboration between an academic health science center and a large safety net hospital
- Serves residents from almost half of the counties in the region
- Demonstrates a model with the potential for significant cost savings
- Transforms the delivery of care
- Contributes expertise to partners to facilitate scaling all or part of the project to other institutions in the region and beyond, through the regional learning collaborative supported by the regional anchor.

References:

Brumley RD, Enguidanos S, Cherin DA. Effectiveness of a home-based palliative care program for end-of-life. Journal of Palliative Medicine, Oct2003, 5(5) 715-724.

Gore JM, Brophy CJ, Greenstone MA, How well do we care for patients with end state chronic obstructive pulmonary disease? A comparison of palliative care and quality of life in COPD and lung cancer. Thorax 2012; 55:1000-1006

Kaasa S, Loge JH Quality of life in palliative care: principles ad practice. Palliative Medicine 2003 17:11-20.

Morden, ME, Chang CH, Jacobson JO, Berke EM, Bynum JPW, Murray KM, Goodman DC. End-of-life care for medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff Apr 2012, 81(4):786-796.

Morrison SR, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med. 2008; 168(16):1783-1790.

127278302.3.42 Pass 3b (127278302.3.16)	3.IT-13.1	Percent improvement in pain assessment (NQF-1637)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.15 Pass 3b (127278302.2.3)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Project meeting notes. HR training Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,222 **Process Milestone 2** P-7: Hire and train staff Data Source: HR records Process Milestone 2 Estimated Incentive Payment: $14,222	**Process Milestone 3** P-2 Establish baseline rates Data Source: Case eligibility protocol Process Milestone 3 Estimated Incentive Payment: $50,130 **Outcome Improvement Target 1** IT-13.1: Percent of palliative care patients who screen positive for pain receive clinical assessment within 24 hours Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 1 Estimated Incentive Payment*:* $50,130	**Outcome Improvement Target 2** IT-13.1: Percent of palliative care patients who screen positive for pain receive clinical assessment within 24 hours Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 2 Estimated Incentive Payment*:* $199,293	**Outcome Improvement Target 3** IT-13.1: Percent of palliative care patients who screen positive for pain receive clinical assessment within 24 hours Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 3 Estimated Incentive Payment*:* $346,107

127278302.3.42 Pass 3b (127278302.3.16)	3.IT-13.1	Percent improvement in pain assessment (NQF-1637)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.15 Pass 3b (127278302.2.3)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,444	Year 3 Estimated Outcome Amount: $100,260	Year 4 Estimated Outcome Amount: $199,293	Year 5 Estimated Outcome Amount: $346,107
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $674,104			

Outcome Measure (Improvement Target): IT-13.2 – Treatment Preferences (NQF-1641)

Unique RHP Outcome Identifier Number – 127278302.3.43 Pass 3b (127278302.3.17)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY 2, DY3, and DY4 are directly related to initial planning processes, education and training activities, and deployment of palliative care and supportive care teams in two separate institutions to demonstrate effective models of care delivery designed to improve quality of care, better outcomes and reduce costs of care.

Process Milestones for this Category 2 project include: P-1 process planning to produce a business plan, P-5 Implementing palliative care for ambulatory patients, P-6 Implementing palliative care for patients during hospitalization through consultations

The Category 2 Improvement milestone for the project is ~~I-11 Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care. The metric is pain management.~~ I-12 Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care with an improvement of scores over time.

Category 3 process milestone include

- P-1 Project planning,
- P-2 establishing baseline for the target population,
- P-5 Disseminate findings to stakeholders.

In DY 4 and DY5 the Outcome Domain is 13 (OD-13) Palliative Care. Three non-standalone measures are selected from the single domain of Palliative Care. These include:

- IT-13.1 Pain assessment
- IT-13.2 Treatment preferences
- IT-5 Per cent of patients receiving palliative care services including a discussion of spiritual/religious concerns.(with chart documentation)

Rationale: Central to the provision of effective palliative care is management of pain (including physical, emotional, and spiritual). The selected outcome measures will be reinforced by charting and data collection that will reinforce delivery of comprehensive palliative care by the teams. Supportive care for people who have debilitating diseases will benefit from supportive care to assist with the myriad advanced planning issues. This will ultimately **improve the quality of care, the quality of life, improve outcomes, and reduce costs.**

Outcome Measure Valuation: The valuation of Category 3 process and outcome measures is predicated on the importance of care, comfort and patient satisfaction above the cost to train and support health care professionals to embrace comfort versus postpone death at all costs. The literature provides ample evidence that palliative care, whether delivered in the hospital, nursing facility, or home, delivered by a multidisciplinary team results in improved quality of

care, increased patient satisfaction, reduction in health care costs, and provider satisfaction. (Brumley; Gore Kaasa ; Morrison ; Morden;). Therefore, the potential benefit and transformation of healthcare delivery derived from adherence to and achievement of the Category 3 metrics will demonstrate that the healthcare providers are functioning effectively as members of a multi-disciplinary team, through training provided in the context of this project and through the learning collaborative, primary care providers will acquire skills with current pain management protocols, and perhaps most significantly, healthcare providers will adopt comfort care as an important and acceptable practice leading to improved quality of life a (Gore, 2012) satisfaction of their patients.

This valuation of this ambitious demonstration project is justified as follows:

- Involves a close collaboration between an academic health science center and a large safety net hospital
- Serves residents from almost half of the counties in the region
- Demonstrates a model with the potential for significant cost savings
- Transforms the delivery of care
- Contributes expertise to partners to facilitate scaling all or part of the project to other institutions in the region and beyond, through the regional learning collaborative supported by the regional anchor.

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Gore JM, Brophy CJ, Greenstone MA, How well do we care for patients with end state chronic obstructive pulmonary disease? A comparison of palliative care and quality of life in COPD and lung cancer. Thorax 2012; 55:1000-1006

Kaasa S, Loge JH Quality of life in palliative care: principles ad practice. Palliative Medicine 2003 17:11-20.

Morden, ME, Chang CH, Jacobson JO, Berke EM, Bynum JPW, Murray KM, Goodman DC. End-of-life care for medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff Apr 2012, 81(4):786-796.

Morrison SR, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med. 2008; 168(16):1783-1790.

127278302.3.43 Pass 3b (127278302.3.17)	3.IT-13.2	Percent improvement in treatment preferences (NQF-1641)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.15 Pass 3b (127278302.2.3)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Project meeting notes. HR training Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,222 **Process Milestone 2** P-7: Hire and train staff Data Source: HR records Process Milestone 2 Estimated Incentive Payment: $14,222	**Process Milestone 3** P-2 Establish baseline rates Data Source: Case eligibility protocol Process Milestone 3 Estimated Incentive Payment: $50,130 **Outcome Improvement Target 1** IT-13.2: Percent of palliative care patients with life sustaining preference documented in chart Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 1 Estimated Incentive Payment*:* $50,130	**Outcome Improvement Target 2** IT-13.2: Percent of palliative care patients with life sustaining preference documented in chart Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 2 Estimated Incentive Payment*:* $199,293	**Outcome Improvement Target 3** IT-13.2: Percent of palliative care patients with life sustaining preference documented in chart Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 3 Estimated Incentive Payment*:* $346,107

127278302.3.43 Pass 3b (127278302.3.17)	3.IT-13.2	Percent improvement in treatment preferences (NQF-1641)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.15 Pass 3b (127278302.2.3)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,444	Year 3 Estimated Outcome Amount: $100,260	Year 4 Estimated Outcome Amount: $199,293	Year 5 Estimated Outcome Amount: $346,107
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $674,104			

Outcome Measure (Improvement Target): IT-13.5 – Percentage of patients receiving hospital. or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF-1647 modified)

Unique RHP Outcome Identification Number: 127278302.3.44 Pass 3b (127278302.3.18)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY 2, DY3, and DY4 are directly related to initial planning processes, education and training activities, and deployment of palliative care and supportive care teams in two separate institutions to demonstrate effective models of care delivery designed to improve quality of care, better outcomes and reduce costs of care.

Process Milestones for this Category 2 project include: P-1 process planning to produce a business plan, P-5 Implementing palliative care for ambulatory patients, P-6 Implementing palliative care for patients during hospitalization through consultations

The Category 2 Improvement milestone for the project is ~~I-11 Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care. The metric is pain management.~~ I-12 Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care with an improvement of scores over time.

Category 3 process milestone include

- P-1 Project planning,
- P-2 Establishing baseline for the target population,
- P-5 Disseminate findings to stakeholders.

In DY 4 and DY5 the Outcome Domain is 13 (OD-13) Palliative Care. Three non-standalone measures are selected from the single domain of Palliative Care. These include:

- IT-13.1 Pain assessment
- IT-13.2 Treatment preferences
- IT-5 Per cent of patients receiving palliative care services including a discussion of spiritual/religious concerns.(with chart documentation)

Rationale: Central to the provision of effective palliative care is management of pain (including physical, emotional, and spiritual). The selected outcome measures will be reinforced by charting and data collection that will reinforce delivery of comprehensive palliative care by the teams. Supportive care for people who have debilitating diseases will benefit from supportive care to assist with the myriad advanced planning issues. This will ultimately **improve the quality of care, the quality of life, improve outcomes, and reduce costs.**

Outcome Measure Valuation: The valuation of Category 3 process and outcome measures is predicated on the importance of care, comfort and patient satisfaction above the cost to train

and support health care professionals to embrace comfort versus postpone death at all costs. The literature provides ample evidence that palliative care, whether delivered in the hospital, nursing facility, or home, delivered by a multidisciplinary team results in improved quality of care, increased patient satisfaction, reduction in health care costs, and provider satisfaction. (Brumley; Gore Kaasa ; Morrison ; Morden;). Therefore, the potential benefit and transformation of healthcare delivery derived from adherence to and achievement of the Category 3 metrics will demonstrate that the healthcare providers are functioning effectively as members of a multi-disciplinary team, through training provided in the context of this project and through the learning collaborative, primary care providers will acquire skills with current pain management protocols, and perhaps most significantly, healthcare providers will adopt comfort care as an important and acceptable practice leading to improved quality of life a (Gore, 2012) satisfaction of their patients.

This valuation of this ambitious demonstration project is justified as follows:

- Involves a close collaboration between an academic health science center and a large safety net hospital
- Serves residents from almost half of the counties in the region
- Demonstrates a model with the potential for significant cost savings
- Transforms the delivery of care
- Contributes expertise to partners to facilitate scaling all or part of the project to other institutions in the region and beyond, through the regional learning collaborative supported by the regional anchor.

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Brumley RD, Enguidanos S, Cherin DA. Effectiveness of a home-based palliative care program for end-of-life. Journal of Palliative Medicine, Oct2003, 5(5) 715-724.

Gore JM, Brophy CJ, Greenstone MA, How well do we care for patients with end state chronic obstructive pulmonary disease? A comparison of palliative care and quality of life in COPD and lung cancer. Thorax 2012; 55:1000-1006

Kaasa S, Loge JH Quality of life in palliative care: principles ad practice. Palliative Medicine 2003 17:11-20.

Morden, ME, Chang CH, Jacobson JO, Berke EM, Bynum JPW, Murray KM, Goodman DC. End-of-life care for medicare beneficiaries with cancer is highly intensive overall and varies widely. Health Aff Apr 2012, 81(4):786-796.

Morrison SR, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med. 2008; 168(16):1783-1790.

127278302.3.44 Pass 3b (127278302.3.18)	3.IT-13.5	Percent improvement in discussion of spiritual/religious concerns (NQF-1647 modified)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.15 Pass 3b (127278302.2.3)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning Data Source: Project meeting notes. HR training Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,222 **Process Milestone 2** P-7: Hire and train staff Data Source: HR records Process Milestone 2 Estimated Incentive Payment: $14,222	**Process Milestone 3** P-2 Establish baseline rates Data Source: Case eligibility protocol Process Milestone 3 Estimated Incentive Payment: $50,130 **Outcome Improvement Target 1** IT-13.5: Percent of palliative care patients with spiritual concern discussion documented in chart Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 1 Estimated Incentive Payment*:* $50,130	**Outcome Improvement Target 2** IT-13.5: Percent of palliative care patients with spiritual concern discussion documented in chart Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 2 Estimated Incentive Payment*:* $199,293	**Outcome Improvement Target 3** IT-13.5: Percent of palliative care patients with spiritual concern discussion documented in chart Improvement Target: TBD Data Source: Medical records Outcome Improvement Target 3 Estimated Incentive Payment*:* $346,107

127278302.3.44 Pass 3b (127278302.3.18)	3.IT-13.5	Percent improvement in discussion of spiritual/religious concerns (NQF-1647 modified)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.15 Pass 3b (127278302.2.3)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,444	Year 3 Estimated Outcome Amount: $100,260	Year 4 Estimated Outcome Amount: $199,293	Year 5 Estimated Outcome Amount: $346,107
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $674,104			

Outcome Measure (Improvement Target): IT ~~6.1 Percent improvement over baseline of patient satisfaction scores~~ 10.1 Quality of Life

Unique RHP Outcome Identifier Number: 127278302.3.45 Pass 3b (127278302.3.19)
Performing Provider: UTHSCT-MSRDP (University Physician Associates) 127278302

Outcome Measures Description: Process outcomes selected to assess implementation of this project tie directly to the process milestone and metrics for this Category 2 redesign transformation project to address a **significant community need** (CN. 1 Insufficient access to primary and specialty services CN. 3 high rates of chronic disease, including asthma; CN.4 high costs due to potentially preventable hospitalizations; and CN. 5 Inappropriate emergency department utilization) as well as **regional goals**: 1) improve quality of care and patient satisfaction, 2) improve the health of populations, 3) reduce the cost of health care, and 4) improve access to services .

DY2 Milestone includes P-3.1 Develop a comprehensive care management program. This will entail establishing **clinical protocols** including definition of parameters to guide follow-up patient coaching/monitoring. The plan will also include development of targeted communities, identification of school and community partners, and establishing a schedule to maximize access to services.

The DY3 process improvement milestone is P-2: **Train staff** in the Chronic Care Mode is the milestone to guide system re-design. DY4 includes Process Milestone P-16: participate in face-to-face learning.

Improvement Milestones in DY 4 and DY5 will measure the per cent of increase in unique patients served by this innovative program (I-21.2) and I-18.1 Improve percentage of patients with self-management goals.

Category 3 Outcome Measure Description: OD- Patient Satisfaction; IT-~~6.1~~ 10.1 The Improvement Target for this project is the percent improvement over baseline of Quality of Life scores using PedsQL survey. Stand alone measure ~~5~~10.1~~: patient's overall health status/functional status~~ demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validate assessment tool, is the milestone metric to demonstrate the effectiveness of this service delivery approach.

Rationale:
This metric was selected because although the proposed delivery model will **transform the system** to provide services by the right staff, in the right place ultimately reducing ED visits and hospitalizations for pediatric asthma, the **hospital-based metrics do not apply**. Further, the focus of this project is on increased access with proactive education and follow-up to support patient self-management of a chronic condition. There is **evidence** to suggest that patient compliance is influenced by the effective use of information systems and self-management support services. (Coleman 2009; Owens 2003; Wagner 2004) Compliance is also tied to the patient's perception that their needs are met, that they have access to the appropriate provider when needed, and that their self-management program is supported. (Malouin 2010) ~~We will administer the **CG-CAHPS Child Primary Care Questionnaire 2.0** the~~ PedsQL as the outcome

improvement metric for this project. This ~~version of the~~ standardized survey takes an objective approach to assess patient's ~~perceptions of consistency of actions performed in three domains including office (in this case mobile unit) staff helpfulness, doctor-patient communication, and timeliness of care. The survey uses a 4-point scale that will facilitate administration and comprehension by the target population for these services. Although the survey was designed to be administered in the context of the Family-Centered Medical Home, we believe it is valid for this population for the following reasons:~~ functional capacity in 4 domains ~~1)~~ it is one of the few standardized, validated survey tools for pediatric patients' core dimensions that captures clinical change over time, and is available in Spanish.~~/services~~, ~~2) if children who receive care from a mobile asthma team do not have an established primary care provider a referral will be made, the team will make the primary care provider aware of the respiratory treatment plan, 3) the CHW will function as a coach to help the child and family implement disease management strategies, 4) this version of CG-CAHPS survey is being used by other states to evaluate their Medicaid program.~~

Outcome Measure Valuation: The valuation of this project takes into consideration both the tangible and intangible benefits ~~to~~ of accurate diagnosis and expanded treatment to effectively control acute episodes among children with asthma. There is evidence that the incidence and prevalence of pediatric asthma has increased significantly in recent years and is projected to remain a growing public health concern; African-American children are over-represented in this group, Wise (2004). Based on evidence that self-management support and coaching is effective to help children comply with recognizing and reducing triggers as well as adhering to their treatment plan Malouin (2012) successful implementation of this project will result in the tangible reduction of health care costs by reducing ED visits for uncontrolled asthma.

The intangible benefits of this project include improved quality of life for patients and their families, the patient's self-confidence in being able to control the disease rather than being a victim, the patient's ability to engage in an active lifestyle thereby diminishing the likelihood of developing co-morbidities.

The value of this project greatly exceeds the costs however, as the intention of the waiver is to demonstrate healthcare system delivery transformation to improve access to and quality of care while reducing costs, the valuation is a cost saving measure for the region.

References

Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the chronic care model in the new millennium. Health Affairs, 2009 2(1):75-85.

Malouin Rebecca, Merten S, (2010) Tools to Evaluate the Pediatric Patient-and Family Centered Medical Home, American Academy of Pediatrics' National Center for Medical Home Implementation; US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau

Owens PL, Thompson J, Elixhauser A et.al., Care of children and adolescents in U.S. Hospitals. Rockville(MD): Agency for Healthcare Research and Quality; 2003. HCUP Fact Book No. R. AHRQ Pub. No. 04-0004

Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi, A. Improving chronic care: translating evidence into action. Health Aff Nov 2001 vol. 20 (5):64-78.

Wise PH (2004) The transformation of child health in the United State. Health Affairs 23(5):9-25.

127278302.3.45 Pass 3b (127278302.3.19)	3.IT-~~6.1~~ 10.1	~~Patient Satisfaction – percent improvement over baseline of patient satisfaction scores~~ Quality of Life	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.16 Pass 3b (127278302.2.4)		
Starting Point/Baseline:	TBD DY 2 & 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project Planning Data Source: Project planning meeting notes, roster of project partners & implementation timeline Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $66,882	**Process Milestone 2** P-2 Establish Baseline rates Data Source: Patient rosters and medical records Process Milestone 2 Estimated Incentive Payment: $273,497	**Outcome Improvement Target 1** IT-~~6.1~~: ~~Percent Improvement over baseline of patient satisfaction scores: overall health & functional status~~ Quality of Life Improvement Target: X% TBD Data Source: ~~CAHPS Child Primary Care Questionnaire~~ PedsQL Outcome Improvement Target 1 Estimated Incentive Payment*:* $760,244	**Outcome Improvement Target 2** IT-~~6.1~~: ~~Percent Improvement over baseline of patient satisfaction scores: overall health & functional status~~ Quality of Life Improvement Target: X% TBD Data Source: ~~CAHPS Child Primary Care Questionnaire~~ PedsQL Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,328,924
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $66,882	Year 3 Estimated Outcome Amount: $273,497	Year 4 Estimated Outcome Amount: $760,244	Year 5 Estimated Outcome Amount: $1,328,924
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,429,547			

Outcome Measure (Improvement Target) IT-6.1 Percent improvement over baseline of patient satisfaction scores
Unique RHP Outcome Identifier Number: 127278302.3.20
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Process outcomes selected for DY 2 and 3 are directly related to the planning components in this project including stakeholder engagement, establishing baseline rates and conducting quality improvement activities. Enhancement of evidence-based disease prevention programs will be achieved through various processes such as:

- Engagement of stakeholders and potential collaborators and develop and plan of implementation (P-1)
- Establish or adapt guidelines and processes for deployment including process improvement plan for referral processes and treatment follow-up (P-1)
- Utilize medical records and quality satisfaction data to establish baseline rates (P-2)
- Conduct quality improvement activities such as Plan-Do-Study-Act (PDSA) (P-4)

In DY3 – 5, a standalone measure is selected from Patient Satisfaction (OD-6, IT-6.1). Through the use of Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) surveys, the impact of service expansion will be measured based upon key domains to be established in the patient satisfaction implementation plan (3.P-1).

Rationale: The rationale for choosing patient satisfaction as related outcome domain is based on the ability of the CG-CAHPS survey to provide standardized data instruments for measuring and addressing patient experiences with providers and office staff (CG-CAHPS). "The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers" (TX HHSC, 2012, p.398).

Outcome Measure Valuation: Early colon cancer screening methods reduce mortality and can decrease cancer incidence through the removal of precancerous lesions (Pignone, 2002). Survival rates are greatest when disease is diagnosed at early stage yet there is currently underutilization of available services in HHSC RHP 1. Through **evidence-based**, outreach and education efforts throughout the region, rural underserved populations, particularly African-American and Hispanic populations, will be targeted to increase the participation in secondary prevention programs available through the UPA. The justification for the value of this project is based upon the:

- Recruitment and/or arrangement for increased access to specialty care including gastroenterology, medical oncology and surgical oncology
- enhanced community outreach initiatives with faith based organizations and other relevant groups in counties/cities throughout RHP 1

References:

Pignone M, Rich M, Teutsch SM, et al. Screening for colorectal cancer in adults at average risk: a summary of the evidence for the U.S. preventive Services Task Force. *Ann Intern Med.* 2002;137:132-141.

Texas Health and Human Services Commission (HHSC). Regional healthcare partnership (RHP) planning protocol, 2012. Available at: http://www.hhsc.state.tx.us/1115-docs/RHP-Planning-Protocol-092412.pdf (last accessed 10-02-2012).

127278302.3.20	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.5		
Starting Point/Baseline:	TBD in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation plan, contact lists, planning meeting minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $52,575 **Process Milestone 2** P-2: Establish baseline rates Data Source: Existing patient satisfaction scores in domains specified in implementation plan (P-1) Process Milestone 2 Estimated Incentive Payment: $52,575	**Process Milestone 3** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Implementation and evaluation guide Process Milestone 3 Estimated Incentive Payment: ~~$276,922.50~~ $138,461 **Outcome Improvement Target 1** IT-6.1: Percent improvement over baseline of patient satisfaction scores Improvement Target: TBD based upon baseline data established in DY 2 (P-2) Data Source: CG-CAHPS survey results or acceptable public reporting tool specified in implementation plan (P-1) Outcome Improvement Target 1 Estimated Incentive Payment*:* ~~$276,922.50~~ $138,461	**Outcome Improvement Target 2** IT-6.1: Percent improvement over baseline of patient satisfaction scores Improvement Target: TBD based upon baseline data established in DY 2 (P-2) Data Source: CG-CAHPS survey results or acceptable public reporting tool specified in implementation plan (P-1) Outcome Improvement Target 2 Estimated Incentive Payment*:* ~~$569,382~~ $427,036	**Outcome Improvement Target 3** IT-6.1: Percent improvement over baseline of patient satisfaction scores Improvement Target: TBD based upon baseline data established in DY 2 (P-2) Data Source: CG-CAHPS survey results or acceptable public reporting tool specified in implementation plan (P-1) Outcome Improvement Target 3 Estimated Incentive Payment*:* ~~$846,352~~ $564,234

127278302.3.20	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.5		
Starting Point/Baseline:	TBD in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $105,150	Year 3 Estimated Outcome Amount: $553,845 $276,922	Year 4 Estimated Outcome Amount: $569,382 $427,036	Year 5 Estimated Outcome Amount: $846,352 $564,234
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* ~~$2,074,729~~ $1,373,342			

Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 Day readmission rate
Unique RHP Outcome Identification number: 127278302.3.46 Pass 3b (127278302.3.21)
Performing Provider: UTHSCT- MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Category 3 process outcomes selected for DY2 and DY3 are directly related to establishing a Learning Collaborative per the HHSC Funding Mechanics Protocol. This innovative approach to improving processes to improve potentially preventable admissions and readmissions for CHF among for healthcare organizations relies heavily on establishing a collegial multidisciplinary transformation team.

Category 3 process outcomes include: P-1-project planning, (P-3) develop and test data systems and (P-4) conduct Rapid Improvement Cycles to improve data collection and intervention activities. ~~(P-7) as an ongoing quality improvement measure.~~ In DY 4 and DY5, the Improvement Targets milestone is from the domain (OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates. As a non-hospital performing provider, the associated performance achievement level for this improvement target Congestive Heart Failure 30 day readmission rate, is to be determined (TBD).

Rationale: Evidence suggests that continuous monitoring of patients with disease processes leading to congestive heart failure can decrease the need for hospitalization to control CHF symptoms (Rich). Given the higher than state rates for CHF in the region this is an important condition to address. CHF is the diagnostic category that will serve to focus the quality improvement processes within five hospital settings to not only achieve a positive outcome for individual patients, the QI process as part of a learning collaborative will serve as the impetus to foster a culture of continuous improvement in safety, quality, and efficiency initially within the participating hospitals. But through learning opportunities sponsored by the RHP, shared information will provide practical support for others to adopt proven strategies.

For this initial plan submission, as a non-hospital performing provider, the associated performance achievement level for this improvement target - Congestive Heart Failure 30 day readmission rate for DY4 and DY5 is to be determined (TBD) during DY3.

Outcome Measure Valuation: This project actively engages five hospitals that serve patients across the expanse of the region. The commitment to a shared learning experience will improve the quality of care and systems efficiency to produce better outcomes for patients with CHF. It will also serve as an important, cost-effective learning opportunity; this is particularly true for these small hospitals where there has been limited assessment of current practice capabilities, where there are few personnel resources dedicated to QI, and where training in systems engineering initiatives have been limited.

The process milestone for DY2 is P-1 planning; this will entail each of the five hospitals designating a Learning Collaborative Team (LCT) who will convene together in person and via web-based connections to learn the philosophy and principles of various QI tools. This

collaborative effort with foster not only skill development but collegial relationships to facilitate open sharing of limitations, challenges, and experience to date. Relationship building among team members from individual institutions as well as across institutions will provide a rich learning environment to develop a shared QI/E language and commitment. Team members will be supported by the project facilitator to analyze data sources, gaps, incompatibilities, and opportunities for improvement as they work towards achieving process milestone P-2 establishing a baseline of congestive heart failure readmissions for each institution. (P-4) and conduct Rapid Improvement Cycles to improve data collection and intervention activities. The collective focus of this effort and the results of this project exceed the cost-saving of accomplishing the improvement target IT-3.2 reduction in CHF 30 day readmissions.

This value-added project contributes significantly to setting a high standard to achieve a culture of quality, efficiency, and safety in each of these five rural hospitals that, through shared case examples delivered in RHP conferences, will serve as models to be emulated by other small rural hospitals in the region, state and nationally. The process undertaken in a learning collaborative approach will contribute to the science of quality improvement through scholarly publications documenting the process and outcomes.

References:

Rich MW, Beckham V, Wittenberg C, Leven CL, Freedland KE, Carney RM. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. NEJM 1995 333(18):1190 – 1195.

127278302.3.46 Pass 3b (127278302.3.21)	3.IT-3.2	Congestive Heart Failure 30 Day readmission rate standalone	
UPA			**127278302**
Related Category 1 or 2 Projects:	127278302.2.17 PASS 3B (127278302.2.6)		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Planning to engage LCT teams, identify timelines and develop an implementation plan Data Source: LCT meeting notes Process Milestone 1 Estimated Incentive Payment *:* $75,349	**Process Milestone 2** P-2: Establish baseline rates Data Source: hospital utilization data for CHF Process Milestone 2 Estimated Incentive Payment: $230,231.50 **Process Milestone 3** P-4 conduct PDSA cycles to improve data collection and intervention activities Data Source: Project data Process Milestone 3 Estimated Incentive Payment: $230,231.50	**Outcome Improvement Target 1** IT-3.2: CHF 30 day readmission rate Improvement Target: TBD Data Source: Patient data Outcome Improvement Target 1Estimated Incentive Payment*:* $484,283	**Outcome Improvement Target 2** IT-3.2: CHF 30 day readmission rate Improvement Target: TBD Data Source: Patient data Outcome Improvement Target 2 Estimated Incentive Payment*:* $791,819
Year 2 Estimated Outcome Amount : $75,349	Year 3 Estimated Outcome Amount: $460,463	Year 4 Estimated Outcome Amount: $484,283	Year 5 Estimated Outcome Amount: $791,819

127278302.3.46 Pass 3b (127278302.3.21)	3.IT-3.2	Congestive Heart Failure 30 Day readmission rate standalone	
UPA			**127278302**
Related Category 1 or 2 Projects:	127278302.2.17 PASS 3B (127278302.2.6)		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,811,914			

Outcome Measure (Improvement Target): IT-1.8 Depression Management: Screening & Treatment Plan for Clinical Depression (PQR 2011, #134)
Unique RHP Outcome Identification Number: 127278302.3.47 Pass 3b (127278302.3.22)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Critical initial processes for this complex project focus on hiring and deploying a team of behavioral health professionals who will be engaged with teaching behavioral health assessment and treatment (as described in the project narrative) for primary care physicians in practice and in training. Therefore, process outcomes for DY 2 is P-1 planning. This metric will be achieved by completing the assessment of team members needed and hiring them to begin implementing the project. A second process measure P-2 will utilize the preliminary work of protocol development by the behavioral health team to support the process milestone for DY 3; P-2 establish a baseline will be the metric by which the project implementation will be measures.

Outcome Domain 1 (OD-1) Primary Care and Chronic Disease Management has been selected as the domain with the best fit for this demonstration project.
Specific metrics to assess the success of this integration effort will include IT-1.8. –Screening and Treatment Plan for Depression will be reported for project DY4 and DY5. Physicians in practice and training (medical residents) will need an opportunity to complete the continuing medical education program, and second year residents will need time to complete the integrated curriculum. Practitioners will need to become familiar with the selected standardized, and widely accepted tool, its administration and interpretation of the results to guide the treatment plan. In addition, they will need the opportunity to practice presenting this tool to the patient and discuss the results in the context of a consultation with or referral to the advanced practice behavioral health specialist to develop a coordinated, integrated care plan. The outcome improvement targets for DY 4 & 5 for this Improvement Target will be determined once the baseline is established in DY 3.

In DY4 & 5, improvement target is IT-9: Depression remission at twelve months is added. Data to support this metric will be evaluated to ascertain the effectiveness of the treatment plan. Rapid cycle feedback to physicians will strengthen the integration model of care by providing the opportunity to refine care based on patient progress, and with evidence of patient improved health status and satisfaction. The outcome improvement targets for DY 4 & 5 for this Improvement Target will be determined once the baseline is established in DY 3.

Rationale:
DY 2 and 3 Category 3 metrics were chosen from Outcome Domain 1. Depression is a frequent co-occurring morbidity for patients who have chronic illness. The goal of this project is to prepare primary care providers to include an assessment of behavioral health needs including depression, as well as counseling and psychopharmacological treatment as needed, as a component of service delivery to improve the quality of care for people with chronic disease.

Improvement Metrics: Given the shortage of behavioral health professionals in the region, this project will provide training and support for primary care physicians by a psychiatrist and advanced practice professionals to integrate the diagnosis and treatment of

depression in patients with chronic physical diseases(s). The project will also capitalize on two residency training programs to leverage the delivery of behavioral health in primary care practices by incorporating behavioral health assessment and treatment opportunities into their didactic and clinical experience. Since more than 82% of the family medicine residency graduates practice in Texas, this project will transform the number of professionals trained to meet the behavioral health needs of patients.

Outcome Measure Valuation: This project represents a significant contribution by increasing the capacity of primary care physicians currently in practice as well as those in training, to develop competencies to integrate behavioral health screening, treatment, and monitoring as part of their routine care plan, especially for patients with a chronic disease diagnosis.

This value of this project is justifiable on the basis of:

- Two tiered training program with the support of a behavioral health care team to integrate services delivered by primary care providers
- Build capacity to transform primary care medicine for the next generation by equipping them with behavior health practice skills during residency following an evidenced based model curriculum.
- Implement training and consultation utilizing tele-mental infrastructure between behavioral health professionals and clinic sites.
- Delivery of integrated services to patients in order to improve quality of life, quality of care, and improve efficiency of the delivery system.

127278302.3.47 Pass 3b (127278302.3.22)	3.IT-1.8	Depression management: Screening and treatment plan for clinical depression (PQR 2011, #134)	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.18 Pass 3b (127278302.2.7)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1*:* Project planning Metric: Hire Behavioral Health professional team members Data Source: Project data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $34,091	**Process Milestone 2** P-2: Establish baseline for target population **Metric:** Establish protocol for administration of PQR9 and related baseline Data Source: project data Process Milestone 2 Estimated Incentive Payment: $182,137	**Outcome Improvement Target 1** IT-1.8: Screening and treatment plan for clinical depression (PQR 2011, #134) Improvement Target: X% TBD Data Source: Patient records Outcome Improvement Target 2 Estimated Incentive Payment*:* $404,268	**Outcome Improvement Target 2** IT-1.8: Screening and treatment plan for clinical depression (PQR 2011, #134) Improvement Target: X% TBD Data Source: Patient records Outcome Improvement Target 3 Estimated Incentive Payment*:* $706,958
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 34,091	Year 3 Estimated Outcome Amount: $ 182,137	Year 4 Estimated Outcome Amount: $ 404,268	Year 5 Estimated Outcome Amount: $ 706,958
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,327,454			

Outcome Measure (Improvement Target): IT-1.9 Depression Management: Remission at Twelve Months (NQF 0710) (Standalone measure)

Unique RHP Outcome Identifier Number: 127278302.3.48 Pass 3b (127278302.3.23)
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Critical initial processes for this complex project focus on hiring and deploying a team of behavioral health professionals who will be engaged with teaching behavioral health assessment and treatment (as described in the project narrative) for primary care physicians in practice and in training. For this standalone metric the DY2 process milestone P-1 planning. This metric will be achieved by completing an implementation plan for the prevention of depression remission at twelve months. A second process milestone for DY3 is P-2 establish a baseline. The behavioral health team will establish a baseline for remission at twelve months based in part on information gathered to develop the implementation plan for this metric.

Outcome Domain 1 (OD-1) Primary Care and Chronic Disease Management has been selected as the domain with the best fit for this demonstration project.
Specific metrics to assess the success of this integration effort will include IT-1.8. –Screening and Treatment Plan for Depression will be reported for project DY4 and DY5. Physicians in practice and training (medical residents) will need an opportunity to complete the continuing medical education program, and second year residents will need time to complete the integrated curriculum. Practitioners will need to become familiar with the selected standardized tool, its administration and interpretation of the results to guide the treatment plan. In addition, they will need the opportunity to practice presenting this tool to the patient and discuss the results in the context of a consultation with or referral to the advanced practice behavioral health specialist to develop a coordinated, integrated care plan. The outcome improvement targets for DY 4 & 5 for this Improvement Target will be determined once the baseline is established in DY 3.
In DY4 & 5, improvement target is IT-9: Depression remission at twelve months is added. Data to support this metric will be evaluated to ascertain the effectiveness of the treatment plan. Rapid cycle feedback to physicians will strengthen the integration model of care by providing the opportunity to refine care based on patient progress, and with evidence of patient improved health status and satisfaction. The outcome improvement targets for DY 4 & 5 for this Improvement Target will be determined once the baseline is established in DY 3.

Rationale:
DY 2 and 3 Category 3 metrics were chosen from Outcome Domain 1. Depression is a frequent co-occurring morbidity for patients who have chronic illness. The goal of this project is to prepare primary care providers to include an assessment of behavioral health needs including depression, as well as counseling and psychopharmacological treatment as needed, as a component of service delivery to improve the quality of care for people with chronic disease.

Improvement Metrics: Given the shortage of behavioral health professionals in the region, this project will provide training and support for primary care physicians by a psychiatrist and advanced practice professionals to integrate the diagnosis and treatment of depression in patients with chronic physical diseases(s). The project will also capitalize on two residency training programs to leverage the delivery of behavioral health in primary care practices by incorporating behavioral health assessment and treatment opportunities into their didactic and clinical experience. Since more than 82% of the family medicine residency graduates practice in Texas, this project will transform the number of professionals trained to meet the behavioral health needs of patients.

Outcome Measure Valuation: This project represents a significant contribution by increasing the capacity of primary care physicians currently in practice as well as those in training, to develop competencies to integrate behavioral health screening, treatment, and monitoring as part of their routine care plan, especially for patients with a chronic disease diagnosis.

This value of this project is justifiable on the basis of:

- Two tiered training program with the support of a behavioral health care team to integrate services delivered by primary care providers
- Build capacity to transform primary care medicine for the next generation by equipping them with behavior health practice skills during residency following an evidenced based model curriculum.
- Implement training and consultation utilizing tele-mental infrastructure between behavioral health professionals and clinic sites.
- Delivery of integrated services to patients in order to improve quality of life, quality of care, and improve efficiency of the delivery system.

127278302.3.48 Pass 3b (127278302.3.23)	3.IT-1.9	Depression management: Remission at Twelve Months	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.18 Pass 3b (127278302.2.7)		
Starting Point/Baseline:	TBD		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1*:* Project planning Metric: Document implementation plans Data Source: Project data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $34,091	**Process Milestone 2 P-2 Establish base line rates** **Metric:** Establish baseline of patients who meet project protocol and are subject to remission Data Source: project data; patient records Process Milestone 2 Estimated Incentive Payment: $182,137	**Outcome Improvement Target 1** IT-1.9: Depression remission at twelve months Improvement Target: TBD Data Source: clinical data Outcome Improvement Target 2 Estimated Incentive Payment*:* $404,268	**Outcome Improvement Target 2** IT-1.9: Depression remission at twelve months Improvement Target: TBD Data Source: Clinical data Outcome Improvement Target 4 Estimated Incentive Payment*:* $706,958
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $34,091	Year 3 Estimated Outcome Amount: $182,137	Year 4 Estimated Outcome Amount: $404,268	Year 5 Estimated Outcome Amount: $706,958
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,327,454			

Outcome Measure (Improvement Target) IT -9.2: ED Appropriate Utilization

Unique RHP Outcome Identification Number: 127278302.3.49 Pass 3b (127278302.3.24)
Performing Provider/TPI: UTHSCT-MSRDP (University Physician Associates) 127278302

Outcome Measure Description: DY 2 is comprised of two process milestones. The first process milestone is **P-1 Project Planning** which will consist of engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. The second process milestone is **P-2 Establishing Baseline Rates** in which the PN program administration will work to establish and then report baseline numbers of the **target patient population** whom have **ED visits related to COPD, Asthma, Diabetes, CHF, CD/HT and BH/SA.**

DY 3 is comprised of one process milestone and one outcome improvement target. The process milestone is **P-3,** the **development** and **testing of data systems** that will hold data and help with reporting of PN and CHW patient flow and disease outcomes. The outcome improvement target, **IT-9.2**, will measure the **reduction of ED visits** among patients followed by the PN/CHW teams who have had past admissions related to **COPD, Asthma, Diabetes, CHF, CD/HT and BH/SA.**

DY 4 is comprised of a single outcome improvement target; **IT-9.2**, which will measure the **reduction of ED visits** among patients followed by the PN/CHW teams who have had past admissions related to **COPD, Asthma, Diabetes, CHF, CD/HT and BH/SA.**

DY 5 is comprised of a single outcome improvement target, **IT-9.2**, which will measure the **reduction of ED visits** among patients followed by the PN/CHW teams who have had past admissions related to any **chronic** or **behavioral health conditions**.

Rationale: The region has a higher than average prevalence of certain chronic diseases, and **admission rates** for **chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF),** and mortality rates from **heart disease** and **chronic lung disease** are among the highest in the state. The majority of counties in Northeast Texas also have higher rates of preventable **hospitalizations for pneumonia, congestive heart failure, high blood pressure, asthma, COPD, and diabetes** compared to the rates for Texas. Further, it was also estimated that over 85,000 individuals regionally have a serious **mental illness**, with well over 100,000 needing treatment for **alcohol/drug use**. Prior research shows that the proposed model will incorporate a more proactive use of information systems and decision support to enhance delivery system design and guide the application of self-management tools for the patient. The self-management support program is expected to enhance health-literacy and disease-specific knowledge. Increased monitoring of health care quality measures such as those adopted for meaningful use in EHRs, progress in achieving behavioral changes, and reduction in high cost utilization By implementing the category 2 project: Implement Patient Care Navigator and CHW chronic disease self management program to **reduce emergency department visits**; the category 3 metrics of **reducing ED visits in Asthma, Diabetes, CHF, COPD, Hypertension, and behavioral**

health and substance abuse can be achieved. Specific percentage deductions anticipated by the implementation of the PN program will be added to outcome improvement targets in DY 3,4, and 5 following DY 2 establishment of baseline data.

Outcome Measure Valuation: East Texas experiences high levels of chronic health and behavioral health morbidity and the rural uninsured populations remain disproportionately affected. There continues to be limited access to both primary and behavioral health services for poor and vulnerable groups in this region. Inappropriate ED utilization is often tied to poor health outcomes and high costs to society. This project is intended to expand and enhance the capacity of providers within the Northeast Texas region to provide preventive and primary care to these patients whom are at high risk for disconnect from institutionalized healthcare. Patient Navigator programs are felt to hold considerable promise for filling gaps in access for primary and behavioral healthcare delivery. Following a six week PN and CHW training series, a collection of teams will be developed and assigned to identified frequent ED users for navigation and educational follow up and care. Use of Category 3, evidence-based measures will demonstrate improvement in outcomes tied to Right Care in the Right Setting. This capacity investment will help to reduce the financial burden to the regional health care system through provision of care in the appropriate setting and reduced utilization of high cost services such as emergency department visits and unnecessary hospitalization. The value of this project is justifiable on the basis of its transformative nature in:

- Addressing CN.2, insufficient access to mental and behavioral health services; CN.3 high rates of chronic disease; and CN.4 high costs due to PPA's.
- Enhanced access to primary care and behavioral health services for a rural/vulnerable population.
- Developing capacity which can increase access to high quality preventive and primary care.
- Building capacity through training of patient navigator sand CHW teams.
- Providing a platform for integration of primary care and behavioral health.
- Reducing inappropriate ED utilization by providing Right Care in the Right Setting.

127278302.3.49 Pass 3b (127278302.3.24)	*3.IT-9.2*	*ED Appropriate Utilization*	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.19 Pass 3b (127278302.2.8)		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 Project Planning – P-1: Data Source: Engage Stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 53,839 **Process Milestone 2** Establish Baseline Rates - P-2: Data Source: Report Baseline Numbers Process Milestone 2 Estimated Incentive Payment: $ 53,839	**Process Milestone 3** Develop and Test Data Systems - P-3 Data Source: Document and Implement Data Systems Process Milestone 3 Estimated Incentive Payment: $ 309,474 **Outcome Improvement Target 1** IT-9.2: Improvement Target: Reduce All ED Visits, % TBD Data Source: EHR, provider data Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 309,474	**Outcome Improvement Target 2** IT-9.2: Improvement Target: Reduce All ED Visits, % TBD Data Source: EHR, provider data Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 761,076	**Outcome Improvement Target 3** IT-9.2: Improvement Target: Reduce All ED Visits, % TBD Data Source: EHR, provider data Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 1,060,397
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 107,678	Year 3 Estimated Outcome Amount: $ 618,948	Year 4 Estimated Outcome Amount: $ 761,076	Year 5 Estimated Outcome Amount: $ 1,060,397
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 2,548,099			

Outcome Measure (Improvement Target): IT-3.1 All cause 30 day readmission rate

Unique RHP Outcome Identification Number: 127278302.3.50 Pass 3b (127278302.3.25)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Decrease all cause readmissions by 7% from baseline by the end of year 5. CSM will baseline all cause readmission rate during year 2. During year 3 CSM plans to decrease all cause readmission by 3% from the baseline established in year 2. During year 4 CSM plans to decrease all cause readmission by 5% from the baseline established in year 2. During year 5 CSM plans to decrease all cause readmission by 7% from the baseline established in year 2.

Rationale: This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardio-respiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. The measure was developed for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. The following was used: the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.

Outcome Measure Valuation: By creating efficiencies in the management of patient illness and chronic disease, there is an opportunity to make better use of resources that best serve the long term of health of the Texarkana area population. The desired outcomes will lead to: reduction in preventable readmissions, hospital admissions, and reduced costs of health services through better health management and education. Lastly, this project is closely aligned with community need CN.4.

127278302.3.50 Pass 3b (127278302.3.25)	*3.IT-3.1*	*All cause 30 day readmission rate*	
	UPA		127278302
Related Category 1 or 2 Projects::	127278302.2.20 Pass 3b (127278302.2.9)		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1– P-2: Establish baseline for all cause readmission rate. Data Source: EHR, Claims **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $78,917	**Outcome Improvement Target 1** [IT-3.1]: Decrease all cause readmission by 3% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 1** Estimated Incentive Payment*:* $319,180	**Outcome Improvement Target 2** [IT-3.1]: Decrease all cause readmission by 5% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 2** Estimated Incentive Payment*:* $ 397,269	**Outcome Improvement Target 3** [IT-3.1]: Decrease all cause readmission by 7% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 3** Estimated Incentive Payment*:* $765,956
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $78,917	Year 3 Estimated Outcome Amount: $319,180	Year 4 Estimated Outcome Amount: $397,269	Year 5 Estimated Outcome Amount: $765,956
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,561,322			

Outcome Measure (Improvement Target): IT.3.2 Congestive Heart Failure (CHF) 30 day readmission rate

Unique RHP Identifier Number: 127278302.3.52 Pass 3b (127278302.3.27)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Decrease Congestive heart failure readmissions by 10% from baseline by the end of year 5. CHRISTUS St. Michael Health System (CSM) will establish the baseline congestive heart failure readmission rate during year 2. During year 3 CSM plans to decrease Congestive heart failure readmissions by 5% from baseline established in year 2. During year 4 CSM plans decrease Congestive heart failure readmissions by 7% from baseline established in year 2. During year 5 CSM Decrease Congestive heart failure readmissions by 10% from baseline established in year 2.

Rationale: This measure estimates the hospital-level, risk-standardized rate of unplanned, Heart failure readmissions after admission for heart failure within 30 days of hospital discharge (RSRR) for patients aged 18 and older. This was chosen as the outcome measure because it is closely aligned with the purpose of which the category 2 pilot was made to effect and supported by the Institute of Health Improvement[61].This will help lower income members of the community because of the limited access to transportation and lower having access to a health professional will assist in their perceived level of health literacy.

Outcome Measure Valuation: This project addresses significant priority regional needs (CN.3 CN.4, CN.6) as a big problem, it requires an investment of additional staff, training, and tablets (for some patients who would be best served by its use) to adequately demonstrate effectiveness of transforming the healthcare delivery system. The specific outcome of reduced CHF readmission rates will lead to a reduction in preventable emergency department visits, and better care management of our most vulnerable patients in addition to increase patient satisfaction in CSM and regional nursing and medical staff to deliver high quality care.

[61] Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012

127278302.3.52 Pass 3b (127278302.3.27)	*3.IT-3.2*	*Congestive Heart Failure 30 day readmission rate*	
UPA			*127278302*
Related Category 1 or 2 Projects::	127278302.2.22 Pass 3b (127278302.2.11)		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1– P-2: Establish baseline congestive heart failure readmission rate. Data Source: EHR, Claims **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $77,044	**Outcome Improvement Target 1** [IT-3.2]: Decrease Congestive heart failure readmissions by 5% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 1** Estimated Incentive Payment*:* $ 311,603	**Outcome Improvement Target 2** [IT-3.2]: Decrease Congestive heart failure readmissions by 7% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 2** Estimated Incentive Payment*:* $387,838	**Outcome Improvement Target 3** [IT-3.2]: Decrease Congestive heart failure readmissions by 10% from baseline. Data Source: EHR, Claims **Outcome Improvement Target 3** Estimated Incentive Payment*:* $747,773
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $77,044	Year 3 Estimated Outcome Amount: $311,603	Year 4 Estimated Outcome Amount: $387,838	Year 5 Estimated Outcome Amount: $747,773
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:$1,524,258***			

Outcome Measure (Improvement Target : IT- 11.1 Addressing Health Disparities in Minority Populations – Improvement in clinical Indicator in identified disparity group (assessment of prostate cancer risk).

Unique RHP Outcome Identification Number: 127278302.3.28

Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description:

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The purpose of this open access clinic is to establish a foundation for transforming the primary care landscape in northeast Texas by emphasizing enhanced chronic disease management through a basic care clinic model in which UTHSCT/UPA will demonstrate a model to deliver care at the right place and right settings. Further, the project will serve minority populations in zip code 75702 who experience disproportionate access barriers and adverse health outcomes. The basic care delivery model aligns with payment reform and will help achieve the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve and rely less on costly emergency department (ED) visits.

The project plans to initiate basic health care and enhance screening services to the target population of zip code 75702. A significant underserved minority population resides in this area. Because they lack access to preventive and acute health care services, two category 3 outcome measures have been chosen by which to measure progress. We will use standalone measure IT-11.1 with a focus on improving a selected clinical indicator (~~TBD~~ assessment of prostate cancer risk in African American men) for area residents, and IT-12.5 a USPSTF endorsed outcome screening measure , screening for high blood pressure in adults, to assess progress on improving preventive health care behaviors among the population. A baseline for metrics for both improvement targets will be established by the end of DY3, the Performing Provider team will then select ~~a USPSTF endorsed screening metric and~~ related intervention targets for X% improvement achieved over baseline in DY4 and DY5. For IT-11.1, the goal will be to increase the number of assessments that are completed for African American men over the age of 45 to evaluate any increased risk for prostate cancer and to document physician-patient communication regarding the decision to undergo prostate cancer screening including Prostate Specific Antigen blood testing with or without a rectal exam (ACS, 2013). For 12.5, the goal will be to increase the number of patients being screened, thus serving to identify adults at an increased risk for cardiovascular disease due to high blood pressure (USPSTF, 2013).

Rationale: Patient dissatisfaction with primary care services is largely related to limited access, disjointed care, and lack of follow-up. Receiving patient feedback allows providers and the care team members to better understand how to tailor care delivery to meet their patient's needs.

The goal of health care improvement via this model is to provide more preventive and primary care in order to keep individuals and families healthy and, therefore, avoid more costly ED and inpatient care. The model will allow the expansion of USPSTF endorsed screening to improve outcome measures resulting from increased primary care capacity. This will facilitate access to a delivery system that is needed to provide the right care at the right time in the right setting especially for the targeted population.

It is well known the national supply of primary care does not meet the demand for primary care services. The goal of health care improvement via the basic care model is to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. The basic care model would allow the expansion of primary care capacity in order to be able to implement a new kind of delivery system that is needed to provide the right care at the right time in the right setting for all patients.

Outcome Measure Valuation: In the U.S. as many as 5 million hospital stays could possibly have been prevented with basic health care, improved access to effective treatment, or patient adoption of healthy behaviors; such efforts lead to reduced ED visits which are a major source of hospital admissions. Hospital costs for potentially

preventable conditions totaled nearly $40 billion—one of every 10 dollars of total hospital expenditures. The implementation and management of this project will have a direct impact on the cost of care by providing early detection through enhanced screening services and reduce utilization of more costly services or advanced disease management in ED and hospital settings.

More significantly, beyond the cost savings to the current health care system that will be realized with this project, is the positive impact on a community whose residents have suffered from a lack of attention.

References:

American Cancer Society (ACS). ACS Guidelines for the Early Detection of Cancer, 2013. Available at: http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for -the-early-detection-of-cancer (last accessed 02-25-13).

Institute of Medicine. The Future of the Public's Health in the 21st Century. Washington, DC: National Academy Press; 2002

Maciosek MV, Coffield AB, et al. Priorities among effective clinical preventive services: results of a systematic review and analysis. Am J Prev Med 2006;31(1): 55-6

National Committee for Quality Assurance. Executive Summary. In: The State of Health Care Quality 2004. Washington, DC; National Committee for Quality Assurance; 2005

U.S. Department of Health and Human Services U.S. Surgeon General. The Power of Prevention, Steps to a Healthier US: A Program and Policy Perspective. Washington, DC: U.S. Department of Health and Human Services; 2003 [cited 2005 Aug 8]

U.S. Preventive Services Task Force (USPSTF). USPSTF A and B recommendations, 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last accessed 02-25-2013).

127278302.3.28	*3.IT-11.1*	Addressing Health Disparities in Minority Populations Improving Clinical Indicator in identified disparity group – assessment of prostate cancer risk	
University Physician Associates			*127278302*
Related Category 1 or 2 Projects:	*127278302.1.8*		
Starting Point/Baseline:	*TBD by DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Clinic patient schedule or other performing provider document or other plans as designated by performing provider. Milestone 1: Estimated Incentive Payment $48,132	Process Milestone 2: P2 Establish baseline rates ~~and select clinical indicator for improvement target.~~ Data source: EHR, project records Milestone 2: Estimated Incentive Payment : $128,524	**Outcome Improvement Target 1:** IT-11.1: Clinical indicator to be improved and disparity group to be determined by provider for the minority population in the zip code 75702. Number of assessments performed for African American men over the age of 45 for an increased risk of prostate cancer and a documented physician communication about decision to be tested for prostate cancer. Improvement Target: ~~Improve selected clinical indicator~~ Increase in assessments by % TBD over established baseline Data Source: EHR, program data Outcome Improvement Target 1 Estimated Incentive Payment*:* $140,501	**Outcome Improvement Target 2:** IT-11.1: Clinical indicator to be improved and disparity group to be determined by provider for the minority population in the zip code 75702. Number of assessments performed for African American men over the age of 45 for an increased risk of prostate cancer and a documented physician communication about decision to be tested for prostate cancer. Improvement Target: ~~Improve selected clinical indicator~~ Increase in assessments by % TBD over established baseline Data Source: EHR, and program data Outcome Improvement Target 1 Estimated Incentive Payment*:* $307,982.40
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $48,132	Year 3 Estimated Outcome Amount: $128,524	Year 4 Estimated Outcome Amount: $140,501	Year 5 Estimated Outcome Amount: $307,982.40
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $625,140			

Outcome Measure (Improvement Target): IT- 12.5 USPSTF-endorsed screening outcome measure – screening for high blood pressure in adults

Unique RHP Outcome Identification Number: 127278302.3.29
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The purpose of this open access clinic is to establish a foundation for transforming the primary care landscape in northeast Texas by emphasizing enhanced chronic disease management through a basic care clinic model in which UTHSCT/UPA will demonstrate a model to deliver care at the right place and right settings. Further, the project will serve minority populations in zip code 75702 who experience disproportionate access barriers and adverse health outcomes. The basic care delivery model aligns with payment reform and will help achieve the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve and rely less on costly emergency department (ED) visits.

The project plans to initiate basic health care and enhance screening services to the target population of zip code 75702. A significant underserved minority population resides in this area. Because they lack access to preventive and acute health care services, two category 3 outcome measures have been chosen by which to measure progress. We will use standalone measure IT-11.1 with a focus on improving a selected clinical indicator (~~TBD~~ assessment of prostate cancer risk in African American men) for area residents, and IT-12.5 a USPSTF endorsed outcome screening measure, screening for high blood pressure in adults, to assess progress on improving preventive health care behaviors among the population. A baseline for metrics for both improvement targets will be established by the end of DY3, the Performing Provider team will then select ~~a USPSTF endorsed screening metric and~~ related intervention targets for X% improvement achieved over baseline in DY4 and DY5. For IT-11.1, the goal will be to increase the number of assessments that are completed for African American men over the age of 45 to evaluate any increased risk for prostate cancer and to document physician-patient communication regarding the decision to undergo prostate cancer screening including Prostate Specific Antigen blood testing with or without a rectal exam (ACS, 2013). For 12.5, the goal will be to increase the number of patients being screened, thus serving to identify adults at an increased risk for cardiovascular disease due to high blood pressure (USPSTF, 2013).

Rationale: Patient dissatisfaction with primary care services is largely related to limited access, disjointed care, and lack of follow-up. Receiving patient feedback allows providers and the care team members to better understand how to tailor care delivery to meet their patient's needs.

The goal of health care improvement via this model is to provide more preventive and primary care in order to keep individuals and families healthy and, therefore, avoid more costly ED and inpatient care. The model will allow the expansion of USPSTF endorsed screening to improve outcome measures resulting from increased primary care capacity. This will facilitate access to a delivery system that is needed to provide the right care at the right time in the right setting especially for the targeted population.

It is well known the national supply of primary care does not meet the demand for primary care services. The goal of health care improvement via the basic care model is to provide more preventive and primary care in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. The basic care model would allow the expansion of primary care capacity in order to be able to implement a new kind of delivery system that is needed to provide the right care at the right time in the right setting for all patients.

Outcome Measure Valuation: In the U.S. as many as 5 million hospital stays could possibly have been prevented with basic health care, improved access to effective treatment, or patient adoption of healthy behaviors; such efforts lead to reduced ED visits which are a major source of hospital admissions. Hospital costs for potentially preventable conditions totaled nearly $40 billion—one of every 10 dollars of total hospital expenditures. The

implementation and management of this project will have a direct impact on the cost of care by providing early detection through enhanced screening services and reduce utilization of more costly services or advanced disease management in ED and hospital settings.

More significantly, beyond the cost savings to the current health care system that will be realized with this project, is the positive impact on a community whose residents have suffered from a lack of attention.

References:

American Cancer Society (ACS). ACS Guidelines for the Early Detection of Cancer, 2013. Available at: http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for -the-early-detection-of-cancer (last accessed 02-25-13).

Institute of Medicine. The Future of the Public's Health in the 21st Century. Washington, DC: National Academy Press; 2002

Maciosek MV, Coffield AB, et al. Priorities among effective clinical preventive services: results of a systematic review and analysis. Am J Prev Med 2006;31(1): 55-6

National Committee for Quality Assurance. Executive Summary. In: The State of Health Care Quality 2004. Washington, DC; National Committee for Quality Assurance; 2005

U.S. Department of Health and Human Services U.S. Surgeon General. The Power of Prevention, Steps to a Healthier US: A Program and Policy Perspective. Washington, DC: U.S. Department of Health and Human Services; 2003 [cited 2005 Aug 8]

U.S. Preventive Services Task Force (USPSTF). USPSTF A and B recommendations, 2013. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last accessed 02-25-2013).

127278302.3.29	3.IT-12.5	~~Category 3 Outcome – ED Utilization~~ Other USPSTF-endorsed screening measures – screening for high blood pressure in adults	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.1.8		
Starting Point/Baseline:	TBD by DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 Project planning Data Source: New primary care schedule or other performing provider document or other plans as designated by performing provider. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $48,132	Process Milestone 2: P-2: Establish baseline rates Data Source: EHR, project records Process Milestone 2 Estimated Incentive Payment: *$128,524*	Outcome Improvement Target 1: IT-12.5: Other USPSTF-endorsed screening outcome measures – screening for high blood pressure in adults Numerator: ~~TBD by performing provider~~ number of patients over the age of 18 who undergo BP screening Denominator: ~~TBD by performing provider~~ number of patients over the age of 18 receiving care at this clinic Improvement Target: ~~x% (TBD)~~ Increase number of patients screened by % TBD derived by baseline established in DY 3 Data Source: EHR, project records Outcome Improvement Target 1 Estimated Incentive Payment*:* $140,501	Outcome Improvement Target 1: IT-12.5: Other USPSTF-endorsed screening outcome measures – screening for high blood pressure in adults Numerator: ~~TBD by performing provider~~ number of patients over the age of 18 who undergo BP screening Denominator: ~~TBD by performing provider~~ number of patients over the age of 18 receiving care at this clinic Improvement Target: ~~x% (TBD)~~ Increase number of patients screened by % TBD derived by baseline established in DY 3 Data Source: Registry/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $307,982.40
Year 2 Estimated Outcome Amount: $48,132	Year 3 Estimated Outcome Amount: $128,524	Year 4 Estimated Outcome Amount: $140,501	Year 5 Estimated Outcome Amount: $307,982.40
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $625,140			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP Outcome ID: 127278302.3.53 Pass 3b (127278302.3.30)
Performing Provider: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description:
This outcome measure will focus on reducing ED utilization for behavioral Health. ~~DY2 will involve a process measure for establishing the baseline rate and DY3-5 will focus on improvements. Improvement targets for DY3-5 will be set once the baseline is established.~~ Based on our recent emergency department activity with behavioral health inpatient admissions, we expect to reduce ER visits for behavioral health patients who have completed inpatient and/or crisis stabilization services within 30 days of discharge by 96 patient visits per year in DY3 with additional decrease by 5% in DY4 and 10% by DY5 compared with projected DY3 established baseline.

Rationale:
The primary goal of this outcome measure is to achieve a more appropriate utilization of the ED by reducing the number of services that would have more appropriately been delivered at an alternate site of care. The ED appropriate Utilization improvement target will measure the true impact the linked intensive outpatient behavioral health project is having on ED utilization. ~~As stated above, improvement targets will be implemented in DY3-5~~. As a demonstration project, our goal is to reduce emergency room visits for behavioral health patients and provide improved continuum of care for patients discharged from inpatient services and/or crisis stabilization.

Outcome Measure Valuation:
In valuing this project, PRMC took into account the extent, to which the implementation of an intensive outpatient behavioral health program would provide cost avoidance with reduced readmissions to inpatient behavioral health programs/hospital admissions. Patients receiving continued counseling and therapy services offered thru an intensive outpatient program are less likely to go into a behavioral health crisis situation that would result in ED/acute care services and/or judicial intervention thus reducing excessive ED costs and costs for local law enforcement and judicial organizations and thereby increase the efficient allocation of resources in Region 1. Furthermore, the program will add a much needed component to the healthcare infrastructure in the community, thus meeting one of the three main goals of the waiver.

127278302.3.53 Pass 3b (127278302.3.30)	*3.IT-9.2*	*ED Appropriate Utilization*	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.23 Pass 3b (127278302.2.12)		
Starting Point/Baseline:	*Baseline to be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline rates Data Source: Reports demonstrating number of behavioral health patients currently receiving treatment in appropriate setting Process Milestone 1 Estimated Incentive Payment *(maximum amount):* **$19,367**	**Outcome Improvement Target 1** IT-9.2: ED Appropriate Utilization Improvement Target: ~~**TBD**~~ Project to reduce ER visits for behavioral health patients who have completed inpatient and/or crisis stabilization services within 30 days of discharge by 96 patient visits per year Data Source: Abstracts data from patient records Outcome Improvement Target 1 Estimated Incentive Payment*:* **$47,260**	**Outcome Improvement Target 2 1**IT-9.2: ED Appropriate Utilization Improvement Target: 5% of DY3 projected baseline Data Source: Abstracts data from patient records Outcome Improvement Target 2 Estimated Incentive Payment*:* **$75,835**	**Outcome Improvement Target 3 1**IT-9.2: ED Improvement Target: 10% of DY3 projected baseline Data Source: Abstracts data from patient records Outcome Improvement Target 3 Estimated Incentive Payment*:* **$181,345**
Year 2 Estimated Outcome Amount: **$19,367**	Year 3 Estimated Outcome Amount: **$47,260**	Year 4 Estimated Outcome Amount: **$75,835**	Year 5 Estimated Outcome Amount: **$181,345**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $323,807**			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Live
Unique RHP Outcome Identifier Number: 127278302.3.31
Performing Provider Name/TPI: UTHSCT – MSRDP (University Physician Associates) 127278302

Outcome Measure Description: Process outcomes selected for DY 2 and 3 include stakeholder engagement, establishing baseline rates and conducting quality improvement activities. Enhancement of evidence-based disease prevention programs will be achieved through various processes such as:
Engagement of stakeholders and potential collaborators and develop and plan of implementation, especially related to purchasing, training, scoring, and storing the PedsQL (P-1)
Establish baseline scores for the PedsQL in the target population (P-2)
Conduct Plan-Do-Study-Act (PDSA) (P-4) cycle to improve data collection and intervention activities

In DY3 – 5, a standalone measure is selected from OD- 10 Quality of Life/ Functional Status, IT 10.1 Quality of Life. Through the use of Pediatric Quality of Life Inventory (PedsQL), the impact of a comprehensive weight management program will be measured based upon key psychosocial domains in a widely used, valid, reliable instrument.

Rationale: The rationale for choosing quality of life as the outcome domain is based on the ability of the PedsQL survey to provide standardized data instruments for measuring improvement in quality of life. The weight management program potentially impacts not only weight but also self-efficacy, confidence, mood, activity level, and school performance. The domains on the PedsQL include physical, social, emotional, and school functioning, and the 23-item survey can be completed in 4 minutes. The PedsQL has been translated into multiple languages, widely used for 15 years, and rigorously evaluated for validity and reliability. (http://www.pedsql.org/about_pedsql.html).

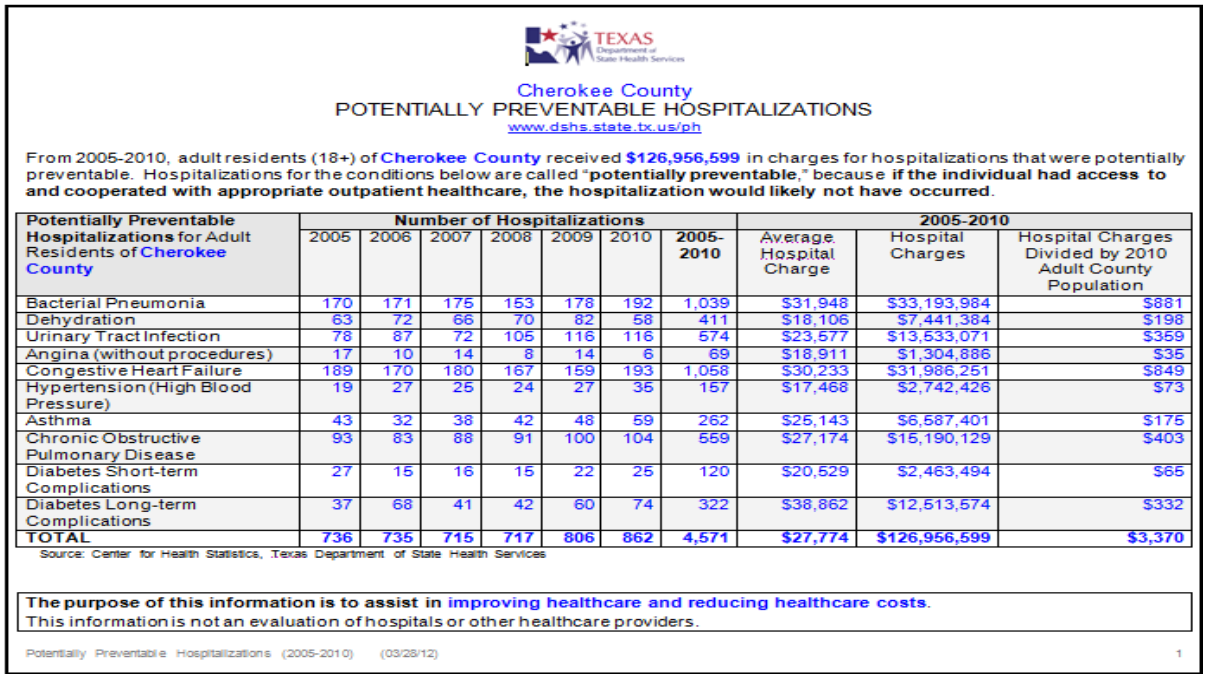
Outcome Measure Valuation: Ultimately, **t**he reason for losing weight is to attain a better quality of life. Obesity is associated with depression, social isolation, and poor school performance. The proposed outcome measure, the PedsQL, skips the intermediate outcome (weight) and goes directly to the ultimate outcome, which is improved quality of life. The monetary value of improved quality of life for children may include increased productivity over a lifetime and lower morbidity resulting in less health care costs. By establishing an evidence based weight management program in partnership with Children's Hospital in Dallas, rural underserved populations will gain access to a state-of-the-art intervention for obesity. The justification for the value of this project is based upon the:
Increased access to specialty care for pediatric obesity
New partnerships between UTHSC Tyler, UT Southwestern in Dallas, and Primary Care Associates in Paris

127278302.3.31	3.IT-10.1	Percent improvement over baseline of patient quality of life	
University Physician Associates			127278302
Related Category 1 or 2 Projects:	127278302.2.13		
Starting Point/Baseline:	TBD in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans, particularly how to implement the PedsQL including purchasing, training, scoring, and storing Data Source: Implementation plan, contact lists, planning meeting minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,109.50 **Process Milestone 2** P-2: Establish baseline rates Data Source: Administer PedsQL to sample of overweight and obese children from Paris pediatrician group (P-1) Process Milestone 2 Estimated Incentive Payment: $5,109.50	**Process Milestone 3** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Implementation and evaluation guide Process Milestone 3 Estimated Incentive Payment: $12,117 **Outcome Improvement Target 1** IT-10.1: Percent improvement over baseline of PedsQL scores Improvement Target: TBD based upon baseline data established in DY 2 (P-2) Data Source: PedsQL score before and after completion of program (P-1) Outcome Improvement Target 1 Estimated Incentive Payment*:* $12,117	**Outcome Improvement Target 2** IT-10.1: Percent improvement over baseline PedsQL scores Improvement Target: TBD based upon baseline data established in DY 2 (P-2) Data Source: PedsQL score before and after completion of program (P-1) Outcome Improvement Target 2 Estimated Incentive Payment*:* $52,825	**Outcome Improvement Target 3** IT-10.1: Percent improvement over baseline of PedsQL scores Improvement Target: TBD based upon baseline data established in DY 2 (P-2) Data Source: PedsQL score before and after completion of program (P-1) Outcome Improvement Target 3 Estimated Incentive Payment*:* $98,311
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone : $10,219	Year 3 Estimated Outcome Amount: $24,234	Year 4 Estimated Outcome Amount: $52,825	Year 5 Estimated Outcome Amount: $98,311
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $185,589			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 130612806.3.1
Performing Provider & TPI: ETMC Jacksonville 130612806

Outcome Measure Description: ETMC Jacksonville's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Dept of State Health Services suggests that in Cherokee County alone there were approximately 4,571 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $126M in charges.



TEXAS Department of State Health Services

Cherokee County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Cherokee County** received **$126,956,599** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Cherokee County**	Number of Hospitalizations						2005-2010			
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	170	171	175	153	178	192	1,039	$31,948	$33,193,984	$881
Dehydration	63	72	66	70	82	58	411	$18,106	$7,441,384	$198
Urinary Tract Infection	78	87	72	105	116	116	574	$23,577	$13,533,071	$359
Angina (without procedures)	17	10	14	8	14	6	69	$18,911	$1,304,886	$35
Congestive Heart Failure	189	170	180	167	159	193	1,058	$30,233	$31,986,251	$849
Hypertension (High Blood Pressure)	19	27	25	24	27	35	157	$17,468	$2,742,426	$73
Asthma	43	32	38	42	48	59	262	$25,143	$6,587,401	$175
Chronic Obstructive Pulmonary Disease	93	83	88	91	100	104	559	$27,174	$15,190,129	$403
Diabetes Short-term Complications	27	15	16	15	22	25	120	$20,529	$2,463,494	$65
Diabetes Long-term Complications	37	68	41	42	60	74	322	$38,862	$12,513,574	$332
TOTAL	**736**	**735**	**715**	**717**	**806**	**862**	**4,571**	**$27,774**	**$126,956,599**	**$3,370**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

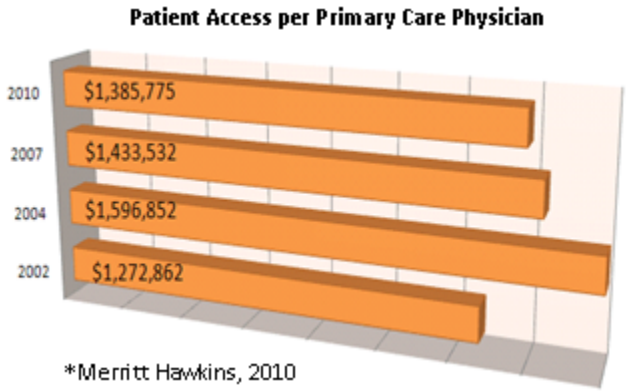
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average

net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $990,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $702,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		3,510
ED visits / year / person		0.45
Potential ED Visits		1,583
ED Visits Reduced @ 15%		237
Avg ED Payment		$425
ED Savings	**$**	**100,904**
IP Admissions / year / person		0.11
Potential IP Admissions		400
Admissions Reduced @ 18%		72
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**889,371**
Total Estimated Savings	**$**	**990,275**



130612806.3.1	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Jacksonville			***130612806***
Related Category 1 or 2 Projects:	***130612806.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $65,025	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $75,372	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $120,946	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $289,218
Year 2 Estimated Total DSRIP Funding: $65,025	Year 3 Estimated Total DSRIP Funding: $75,372	Year 4 Estimated Total DSRIP Funding: $120,946	Year 5 Estimated Total DSRIP Funding: $289,218
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$550,561***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 130612806.3.2
Performing Provider & TPI: ETMC Jacksonville 130612806

Outcome Measure Description: ETMC Jacksonville's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Dept of State Health Services suggests that in Cherokee County alone there were approximately 4,571 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $126M in charges.

TEXAS Department of State Health Services

Cherokee County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Cherokee County** received **$126,956,599** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Cherokee County**	**Number of Hospitalizations**						**2005-2010**	**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	170	171	175	153	178	192	1,039	$31,948	$33,193,984	$881
Dehydration	63	72	66	70	82	58	411	$18,106	$7,441,384	$198
Urinary Tract Infection	78	87	72	105	116	116	574	$23,577	$13,533,071	$359
Angina (without procedures)	17	10	14	8	14	6	69	$18,911	$1,304,886	$35
Congestive Heart Failure	189	170	180	167	159	193	1,058	$30,233	$31,986,251	$849
Hypertension (High Blood Pressure)	19	27	25	24	27	35	157	$17,468	$2,742,426	$73
Asthma	43	32	38	42	48	59	262	$25,143	$6,587,401	$175
Chronic Obstructive Pulmonary Disease	93	83	88	91	100	104	559	$27,174	$15,190,129	$403
Diabetes Short-term Complications	27	15	16	15	22	25	120	$20,529	$2,463,494	$65
Diabetes Long-term Complications	37	68	41	42	60	74	322	$38,862	$12,513,574	$332
TOTAL	**736**	**735**	**715**	**717**	**806**	**862**	**4,571**	**$27,774**	**$126,956,599**	**$3,370**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $695,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $493,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		13,965
% Clinic Appropriate		15%
Clinic Appropriate Patients		2,095
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**891,086**
Clinic Payment @ 78% savings	$	196,039
Total Estimated Savings	**$**	**695,047**

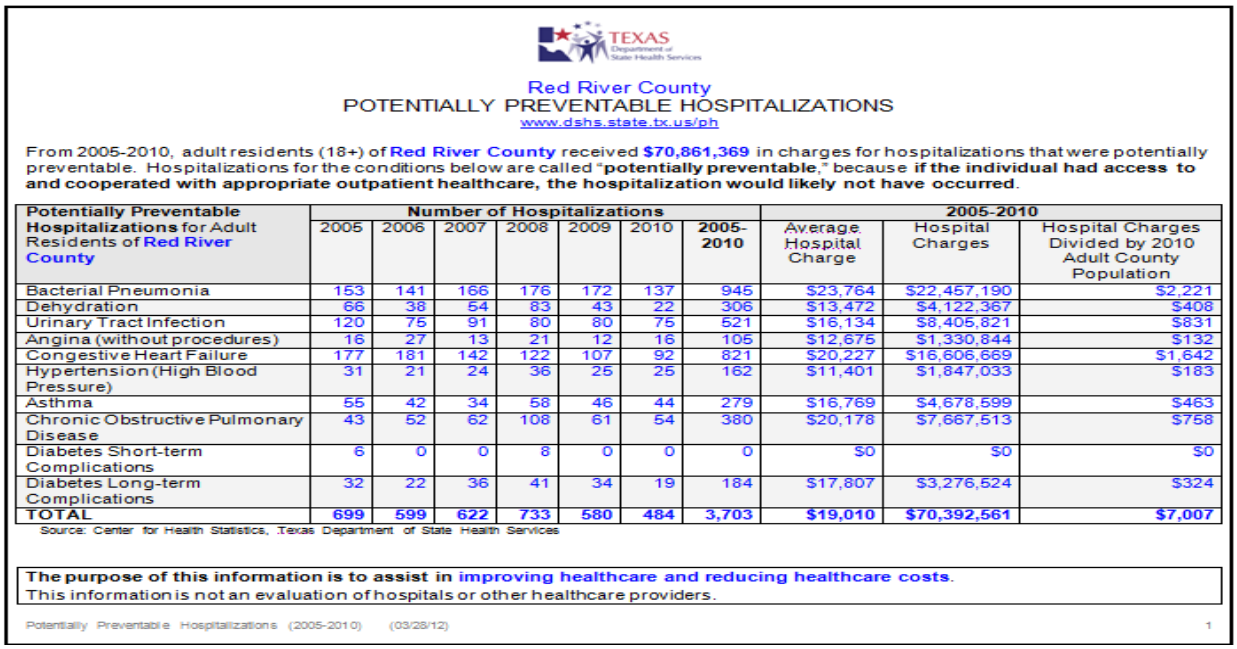
(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

130612806.3.2	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Jacksonville			***130612806***
Related Category 1 or 2 Projects:	***130612806.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $45,639	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $52,902	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $84,889	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $202,995
Year 2 Estimated Total DSRIP Funding: $45,639	Year 3 Estimated Total DSRIP Funding: $52,902	Year 4 Estimated Total DSRIP Funding: $84,889	Year 5 Estimated Total DSRIP Funding: $202,995
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$386,424***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 130862905.3.1
Performing Provider & TPI: ETMC Clarksville 130862905

Outcome Measure Description: ETMC Clarksville's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Dept. of State Health Services suggests that in Red River County alone there were approximately 3,703 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $70M in charges.



TEXAS Department of State Health Services

Red River County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Red River County** received **$70,861,369** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Red River County**	Number of Hospitalizations						2005-2010			
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	153	141	166	176	172	137	945	$23,764	$22,457,190	$2,221
Dehydration	66	38	54	83	43	22	306	$13,472	$4,122,367	$408
Urinary Tract Infection	120	75	91	80	80	75	521	$16,134	$8,405,821	$831
Angina (without procedures)	16	27	13	21	12	16	105	$12,675	$1,330,844	$132
Congestive Heart Failure	177	181	142	122	107	92	821	$20,227	$16,606,669	$1,642
Hypertension (High Blood Pressure)	31	21	24	36	25	25	162	$11,401	$1,847,033	$183
Asthma	55	42	34	58	46	44	279	$16,769	$4,678,599	$463
Chronic Obstructive Pulmonary Disease	43	52	62	108	61	54	380	$20,178	$7,667,513	$758
Diabetes Short-term Complications	6	0	0	8	0	0	0	$0	$0	$0
Diabetes Long-term Complications	32	22	36	41	34	19	184	$17,807	$3,276,524	$324
TOTAL	**699**	**599**	**622**	**733**	**580**	**484**	**3,703**	**$19,010**	**$70,392,561**	**$7,007**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

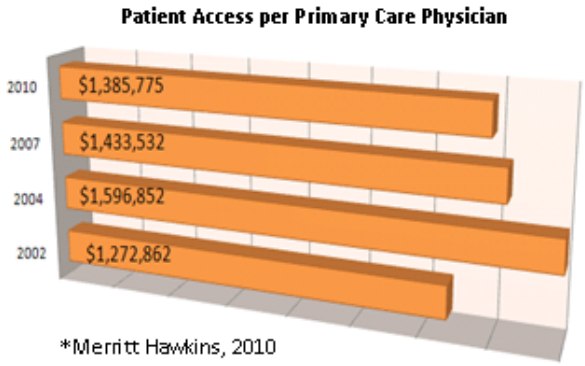
Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $700,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $631,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Primary Care Capacity		
Total New Clinic Patients		2,467
ED visits / year / person		0.45
Potential ED Visits		1,113
ED Visits Reduced @ 15%		167
Avg ED Payment		$425
ED Savings	**$**	**70,932**
IP Admissions / year / person		0.11
Potential IP Admissions		281
Admissions Reduced @ 18%		51
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**625,197**
Total Estimated Savings	**$**	**696,129**

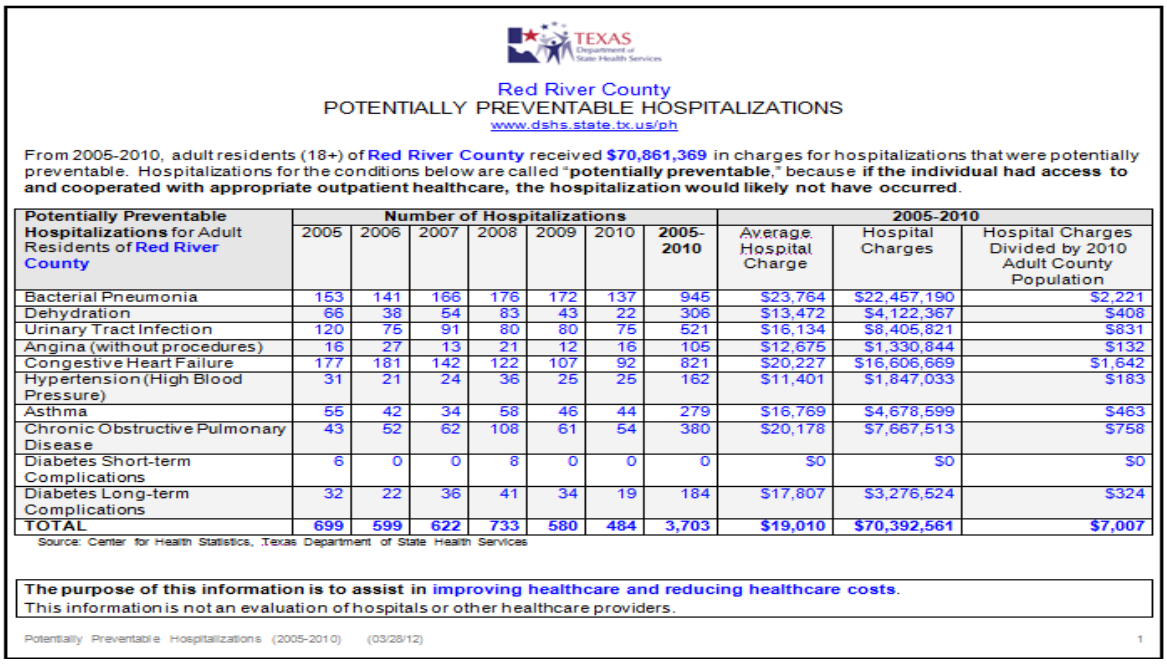


130862905.3.1	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Clarksville			***130862905***
Related Category 1 or 2 Projects:	***130862905.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $58,453	**Process Milestone 2 Estimated Incentive Payment:** $67,754	**Outcome Improvement Target 1 Estimated Incentive Payment:** $108,722	**Outcome Improvement Target 2 Estimated Incentive Payment:** $259,987
Year 2 Estimated Total DSRIP Funding: $58,453	Year 3 Estimated Total DSRIP Funding: $67,754	Year 4 Estimated Total DSRIP Funding: $108,722	Year 5 Estimated Total DSRIP Funding: $259,987
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$494,917***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 130862905.3.2
Performing Provider & TPI: ETMC Clarksville 130862905

Outcome Measure Description: ETMC Clarksville's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Dept. of State Health Services suggests that in Red River County alone there were approximately 3,703 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $70M in charges.



TEXAS Department of State Health Services

Red River County
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From 2005-2010, adult residents (18+) of **Red River County** received **$70,861,369** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Red River County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	153	141	166	176	172	137	945	$23,764	$22,457,190	$2,221
Dehydration	66	38	54	83	43	22	306	$13,472	$4,122,367	$408
Urinary Tract Infection	120	75	91	80	80	75	521	$16,134	$8,405,821	$831
Angina (without procedures)	16	27	13	21	12	16	105	$12,675	$1,330,844	$132
Congestive Heart Failure	177	181	142	122	107	92	821	$20,227	$16,606,669	$1,642
Hypertension (High Blood Pressure)	31	21	24	36	25	25	162	$11,401	$1,847,033	$183
Asthma	55	42	34	58	46	44	279	$16,769	$4,678,599	$463
Chronic Obstructive Pulmonary Disease	43	52	62	108	61	54	380	$20,178	$7,667,513	$758
Diabetes Short-term Complications	6	0	0	8	0	0	0	$0	$0	$0
Diabetes Long-term Complications	32	22	36	41	34	19	184	$17,807	$3,276,524	$324
TOTAL	**699**	**599**	**622**	**733**	**580**	**484**	**3,703**	**$19,010**	**$70,392,561**	**$7,007**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $293,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $265,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		5,889
% Clinic Appropriate		15%
Clinic Appropriate Patients		883
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**375,768**
Clinic Payment @ 78% savings	$	82,669
Total Estimated Savings	**$**	**293,099**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

130862905.3.2	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Clarksville			***130862905***
Related Category 1 or 2 Projects:	***130862905.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $24,611	**Process Milestone 2 Estimated Incentive Payment:** $28,527	**Outcome Improvement Target 1 Estimated Incentive Payment:** $45,777	**Outcome Improvement Target 2 Estimated Incentive Payment:** $109,466
Year 2 Estimated Total DSRIP Funding: $24,611	Year 3 Estimated Total DSRIP Funding: $28,527	Year 4 Estimated Total DSRIP Funding: $45,777	Year 5 Estimated Total DSRIP Funding: $109,466
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$208,380***			

Outcome Measure (Improvement Target): IT-6.1-Percent Improvement Over Baseline of Patient Satisfaction Scores.

Unique RHP Outcome Identification Number(s): 131037704.3.1
Performing Provider Name/TPI: Hopkins County Memorial Hospital 131037704.

Outcome Measure Description: Our process milestones will be establishing the baseline rates (P-2) on patient satisfaction surveys for the new PCPs using the NRC Picker Survey which will occur in DY2. We will then disseminate the findings from the survey (P-5) to the new PCP to determine best practices and successful processes. The improvement milestones will be a percentage improvement of patient satisfaction scores over the baseline year (IT-6.1). This will be determined in DY2 and the outcome improvement targets will be per cent improvements for DY3, DY4 and DY5. The focus will be on survey will be to improve timeliness of care, appointments, and information (IT-6.1.1). The questions that are key drivers to improving timeliness of care, appointments and information are: (1) During your most recent visit, did you get as much information about your condition and treatment as you wanted from this provider; (2) During your most recent visit, did this provider give you easy to understand information about the your health questions and concerns; (3) During your most recent visit, did this provider explain things in a way that was easy to understand; (4) In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed; and (5) In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed.

Rationale: The hospital district wants to fulfill its mission of providing an exceptional patient experience through quality patient-centered care within the hospital and clinic settings and attract the best staff and physicians. Our vision is to be a leader in Northeast Texas by offering high quality care with hospital and physician services that meet the healthcare needs of our region so our patients will recommend us to others. We will use patient satisfaction surveys to measure the patients' perspectives on care which will allow the hospital district to make objective and meaningful comparisons between institutions on domains that are important to consumers. We will disseminate the findings including lessons learned and best practices to the PCPs. Expanding access to quality care is important to improve the health of our region that would include all income levels of our region's population. The outcome improvement targets will be determined in DY 2 for implementation in DY 3.

Outcome Measure Valuation: The outcomes that will be measured by hiring additional PCPs are (1) timely care, appointments and information; (2) cost effective delivery of quality care; (3) increased continuity of care; and (4) increased patient satisfaction. All these factors will benefit our community and serve all income levels. The trend is for physicians to be employed rather than independent practitioners so the expectation is for the hospital district to take on the risk and the expense of employing physicians without any additional outside funding sources. There are benefits to employing physician such as teamwork in the coordination of care for the patient and increased continuity of care. There is also an accountability system in place with

the employment of physicians. And with the addition of two more PCPs, there will be improved access, timeliness of care and sharing of information. This will directly affect patient satisfaction and have a positive influence on the community's image of the hospital's services. Another valuable aspect of increasing access to PCP is the transitioning of patients out of the emergency department and aligning them with the primary care system in order to receive coordinated care and appropriate follow-up care. With the Emergency Department as one of the most expensive accesses to care, a shift in primary care visits from the emergency room to a clinic visit will be a cost savings to the hospital and to the patient. And lastly, there is great value in the opportunity to share the information received on a patient satisfaction survey with the PCPs and improve processes based on the survey results. The valuation is based on the expansion of primary care providers and support staff to deliver the right care, in the right place by the right provider, and the additional resources needed to administer the satisfaction tool and implement process improvement measures.

131037704 .3.1	3.I IT-6.1	Patient Satisfaction	
Hopkins County Memorial Hospital			131037704
Related Category 1 or 2 project:	131037704. 1.1		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-2 Establish baseline rates on patient satisfaction surveys for two new PCPs. Metric: Baseline score Goal: Baseline score determined Data Source: NRC Picker Survey Process Milestone 1 Estimated Incentive Payment*:* $49,334.50 **Process Milestone 2** P-5: Disseminate findings including lessons learned and best practices new PCPs. Metric: Discuss two best practices and implement findings Goal: Best 2 practices implemented Data Source: Hopkins County Physician Service Board Meeting minutes. Process Milestone 2 Estimated Incentive Payment: $49,334.50	**Outcome Improvement Target 1:** IT-6.1. Per cent improvement over baseline of patient satisfaction scores. Metric: 2% increase over baseline Goal: Patient satisfaction scores improved by 2% over baseline. Data Source: NRC Picker Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $81,693	**Outcome Improvement Target 2:** IT-6.1. Per cent improvement over DY 3 of patient satisfaction scores. Metric: 3.5% increase over baseline Goal: Patient satisfaction scores improved by 3.5% over baseline Data Source: NRC Picker Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $122,350	**Outcome Improvement Target 3** IT-6.1. Per cent improvement over DY 4 of patient satisfaction scores. Metric: 4% increase over baseline Goal: Patient satisfaction scores improved by 4% over baseline Data Source: NRC Picker Survey Outcome Improvement Target 3 Estimated Incentive Payment*:* $302,375

131037704 .3.1	3.I IT-6.1	Patient Satisfaction	
Hopkins County Memorial Hospital			131037704
Related Category 1 or 2 project:	131037704. 1.1		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $98,669	Year 3 Estimated Outcome Amount: $81,694	Year 4 Estimated Outcome Amount: $122,350	Year 5 Estimated Outcome Amount: $302,375
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $605,088			

Outcome Measure (Improvement Target):IT-5.1-Improved Cost Savings: Demonstrate Cost Savings in Care Delivery

Unique RHP Outcome Identification Number(s): 131037704.3.2
Performing Provider: Hopkins County Memorial Hospital 131037704

Outcome Measure Description: Cost of Illness analysis, process milestones P-2 Establishing baseline costs for CHF patients, P-5 Disseminating findings and best practices to physicians caring for CHF patients and IT-5.1 Improve cost savings in providing care to CHF patients. Once the baseline costs are calculated in DY3, percentage improvements over the baseline will be established for DY4 and DY5.

Rationale: CHF is one of our top 10 DRGs so a large volume of our community is affected by CHF either through their own health situations or the health needs of family members. This project option was selected in order to identify costs of a high impact DRG, Congestive Heart Failure (CHF). There were approximately 100 patients that were admitted with a diagnosis related to CHF. CHF is an important health challenge because it is pervasive in Hopkins County. People have higher incidences here and are more prone to CHF due to poor dietary habits, lack of education and income levels below the state average. The risk-adjusted mortality rate from our hospital is 5.96 as compared to the Texas rate of 3.02. This information is from the DSHS website most recent data of 2006. There are wide variations in how the patients are treated during their hospital stay. This variation in care is driven by the fact that the patients are cared for by a variety of providers. Each provider may be working from a treatment algorithm that varies substantially by provider.

We will expand our hospitalists program to reduce the number of providers who care for the CHF patient and decrease the variation of care and thus the reduction in costs in providing the care. Currently, Hopkins County Memorial Hospital's 30 day re-admission rate for CHF is 22.5%. Reducing this to 18% would place our hospital among the top performers in the US. This would be one aspect of reducing the cost of care to CHF patients and will be one of our targets in DY5. Although we do not have all the outcome improvement targets established, we will be looking such things at discharge instruction rates, prescriptions at discharges, and follow-up care after discharge.

Outcome Measure Valuation: Implementing a cost accounting system will totally change the way that costs are managed in the hospital setting. Truly understanding the cost by illness will be invaluable when encouraging the physicians to lower the cost of care to their patients. We will conduct quality improvement methods to improve the processes in caring for our patients while reducing cost and be part of our education to the care providers. This will impact all providers who take care of patients in the hospital setting. The expansion of our hospitalist program will help provide patient education on CHF from the point of admission to discharge to the post discharge follow-up care. This continuity in care and education will lead to cost avoidance if we can lower the readmission rate for CHF patients. Not only will this affect the patient with CHF, but as the scope of this project extends to other diseases, it will benefit a multitude of our patients. And this will not be limited to a certain population but will be available to every in-patient. Part of the valuation will be based on the cost savings of attaining the goal of lowering the CHF readmission rate from our current 22.5% to the national average of 18%. The other part of the valuation will be reducing the difference between cost of care and reimbursement of care for CHF. Another part of the valuation will be the benefit to the patient with CHF with reduced prescription costs and cost avoidance of readmission costs.

131037704. 3.2	*3.2 IT-5.1*	*Cost of Care*	
Hopkins County Memorial Hospital			131037704
Related Category 2 Project:	131037704.2.1		
Starting Point/Baseline:	Baseline TBD in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1. P-1. Project planning identifying the needed resources for cost of illness analysis Metric: Identified resources Goal: Completed cost of illness analysis Data Source: Requirements from MEDITECH operational and resource documents Process Milestone 1 Estimated Incentive Payment $ 42,287	**Process Milestone 2.** P-2. Establish baseline costs for providing care to CHF patients Metric: Baseline Cost from cost accounting system Goal: Baseline cost determined Data Source: MEDITECH cost accounting system Process Milestone 2 Estimated Incentive Payment: $40,846.50 **Process Milestone 3.** P-5. Disseminate findings and best practices to physicians caring for CHF patients Metric: Discuss two best practices with physicians and implement findings Goal: Best practices implemented Data Source: Minutes of Medical Service Committee Meetings Process Milestone 3 Estimated Incentive Payment: $40,846.50	**Outcome Improvement Target 1.** IT-5.1. Improved cost savings in providing care to CHF patients over baseline Metric: Reduce cost by 5% over baseline Goal: Cost reduced by 5% over baseline Data Source: Cost of Illness Analysis Outcome Improvement Target 1 Estimated Incentive Payment: $139,829	**Outcome Improvement Target 2.** IT-5.1. Improved cost savings in providing care to CHF patients over DY4 Metric: Reduce Cost by 7.5 % over baseline Goal: Cost reduced by 7.5% over baseline Data Source: Cost of Illness Analysis Outcome Improvement Target 2 Estimated Incentive Payment: $321,274

131037704. 3.2	*3.2 IT-5.1*	*Cost of Care*	
Hopkins County Memorial Hospital			131037704
Related Category 2 Project:	131037704.2.1		
Starting Point/Baseline:	Baseline TBD in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $42,287	Year 3 Estimated Outcome Amount: $81,692	Year 4 Estimated Outcome Amount: $139,828	Year 5 Estimated Outcome Amount: $321,275
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $585,082			

Outcome Measure/Improvement Target: IT-9.4 Other Improvement Outcomes
Unique Project ID: 131037704.3.3
Preforming Provider Name/TPI: Hopkins County Memorial Hospital 131037704.

Outcome Measure Description: Our process milestones will be establishing the baseline number (P-2) for non-urgent patent encounters in the Emergency Department that could have been treated in a primary care setting which will occur in DY2. In the last two fiscal years, 10,000 of the total 32, 000 total encounters were Level 1 and Level 2. Aggregate information will be gathered on these patients, then disseminated and discussed with the Emergency Department physicians to develop an appropriate triage process to adequately redirect these patients to the primary care setting, targeting uninsured and underinsured patients. The outcome improvement targets for DY3 through DY5 will be to decrease Level 1 and Level 2 encounters for all payers by 20% over the three year time frame.

Rationale: Our focus will be to provide the right care in the right setting. Non-urgent/emergent patients will be identified in the ED and given the option to be seen in the ED with the understanding that they will be placed in a queue and charged $150.00 for the visit. If they choose not to be seen in the ED, they will be referred to our clinic. Patients who are referred will be given a unique identifier in order to ascertain whether or not they followed up at our primary care clinic. Not only do we want to reduce the number of Level 1 and Level 2 ED encounters but we also want to make sure that patients have access to and use the primary care clinic for their care. We will focus on the reduction of all Level 1 and Level 2 encounters as a total of all ED encounters and we will also look to reduce the percentage of uninsured and underinsured non-urgent encounters to the total number of Level 1 and Level 2 encounters. We cannot reduce non-urgent encounters without increasing access to primary care providers. With our DSRIP project 131037704.1.2, we are establishing a primary care clinic with suitable hours and staff in order to provide these patients with non-urgent needs a more appropriate cost, price effective and accessible setting.

Valuation: A portion of the valuation is based on the cost savings to our patients. The average ED charge for Level 1 and Level 2 encounters over the last two years has been $300 compared to a PCP office charge of $100. The savings for the 750 patients would be $150,000. By seeking the right care in the right setting, the patient will see a reduction in their charges for care. Valuation of the project also included cost avoidance with reduced Emergency Department costs. The average cost for the hospital to provide care for Level 1 and Level 2 patients in the ED is $125 so the decrease in encounters by 750 over a three year period would be a cost savings of $93,750.

131037704. 33	*3.3 IT-9.4*	OTHER OUTCOME IMPROVEMENT TARGET-REDUCE LEVEL 1 AND LEVEL2 ED ENCOUNTERS	
Hopkins County Memorial Hospital			131037704
Related Category 2 Project:	131037704.1.2		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1. P-2. Establish baseline numbers for Level 1 (L1)and Level 2 (L2) ED encounters Metric: documentation of encounters Goal: baseline established Data Source: EHR Process Milestone 1 Estimated Incentive Payment $ 5,707 **Process Milestone 2:** P-5 Disseminated findings to stakeholders Metric: :Discussion of improvement plans Goal: Education complete for plans to reduce L1 and L2 ED encounters Process Milestone 2 Estimated Incentive Payment $ 5,707	**Outcome Improvement Target 1:** Reduction in L1 and L2 ED encounters Metric: Documentation of encounters Goal: 350 less encounters over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $13,534	**Outcome Improvement Target 2:** Reduction in L1 and L2 ED encounters Metric: Documentation of encounters Goal: 600 less encounters over baseline Data Source: EHR Outcome Improvement Target 2Estimated Incentive Payment: $22,125	**Outcome Improvement Target 3:** Reduction in L1 and L2 ED encounters Metric: Documentation of encounters Goal: 750 less encounters over baseline Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment: $53,288
Year 2 Estimated Outcome Amount: $11,414	Year 3 Estimated Outcome Amount: $13,534	Year 4 Estimated Outcome Amount: $22,125	Year 5 Estimated Outcome Amount: $53,288
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $100,361			

Outcome Measure/Improvement Target: IT-3.2 Congestive Heart Failure 30 Day Re-admission Rate
Unique Project ID: 131037704.3.4
Preforming Provider Name/TPI: Hopkins County Memorial Hospital 131037704.

Outcome Measure Description: Hopkins County Memorial Hospital (HCMH) will implement or expand the care transition program to provide significantly enhanced continuity of care for congestive heart failure patients improving their lives and outcome and decreasing their readmissions to the hospital. By focusing on DHF patients in this initiative, the protocol will create a much smoother transition of care from an inpatient setting to an outpatient setting. This will be accomplished by discharging the patient from the hospital and admitting them to an aftercare program. HCMH will create and implement discharge care protocols for CHF patients through a re-engineered discharge (RED) design. The three core components of the RED will be the assignment of discharge advocates, the development of specific after hospital care plans and frequent follow up phone calls to the patients' homes with the development of specific protocols to deal with specific events as thy might arise for the patient in the home setting. Discharge planning will start at the time the patient is admitted teaching them how to take their own blood pressures, weigh themselves, record the information and communicate it appropriately to a health care professional. The program will also provide for follow up care with the primary care physician with in the first week of discharge, daily phones calls through the first four days post discharge and reinforcement of diet and food choices, the importance of daily weights, and use of medications.

Rationale: Patients leave the hospital many times not knowing why they were admitted, what was done for them in the hospital and how to care for themselves once discharged. In particular, patients often leave not understanding their medications, how to take them properly, what signs and symptoms to look for what constitutes a side effect and what constitutes an exacerbation of the disease process. This lack of knowledge frequently causes patients to be re-seen in the emergency room and readmitted as if they do not have reliable resources to get their answers because there is typically no proactive follow up. The three core elements of a discharge advocate, after hospital care plan and follow up one calls will provide patent centered education, comprehensive discharge planning and post discharge reinforcement of appropriate diet, fluid intake , and use of medications all in a seamless process. Creating a coordinated transition from the inpatient service to the outpatient serve will have multiple benefits to the patient experience. It will significantly enhance safety compliance, decrease readmissions and decrease return visits to the Emergency Department. With timely post hospital stay follow up, problems such deterioration of clinical health status can be quickly identified and addressed. Reducing expensive and unnecessary readmission will free up resources for care at more appropriate levels.
Valuation: A portion of the valuation is based on the cost savings to our patients and a portion is based on the cost savings to the hospital. According to a 2010 AHRQ study, the cost of a CHF readmission is $13,000. With a robust care transition program, readmissions will decline and the patient will not be responsible for their deductibles and the hospital will not have the cost of care for the readmitted patient. Valuation of the project can be based on cost avoidance with reduced Emergency Department costs. With a focus on follow up calls, the scheduling of post discharge visits with the primary physician and patient education, the patient will not have a need to visit the Emergency Department, thus avoiding the high cost of emergency care. A reliable and comprehensive discharge plan, along with post-discharge support can improve health outcomes and ensure quality transitions and the value of this project will also be based on the accomplishments of these goals.

131037704. 3.4	*3.4 IT-3.2*	Potentially Preventable Re-Admissions-30 Day Admission Rates	
Hopkins County Memorial Hospital			131037704
Related Category 2 Project:	131037704.2.2		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1. P-1 Project Planning-engaging stakeholders, identify needed resources and document implementation plans **Metric**: Documentation of protocols and discharge planning program **Goal:** Protocols and discharge planning program established **Data Source**: Meeting minutes, approved protocols **Process Milestone 1 Estimated Incentive Payment** $ 4314.67 **Process Milestone 2.** P-5. Disseminate findings and best practices to discharge planning team **Metric**: Discuss program expectations **Goal:** Education complete on best practices to discharge planning team **Data Source**: Meeting minutes **Process Milestone 2 Estimated Incentive Payment** $ 4314.67 **Process Milestone 3.** P-2. Establish baseline of CHF patients and readmission rate of CHF patient **Metric**: Baseline Cost from cost accounting	**Outcome Improvement Target** 1:IT3 3.2 Congestive Heart Failure 30 day readmission rate **Metric**: Reduce CHF readmission rate by 5% over baseline Goal: 5% reduction in CHF readmission rate over baseline **Data Source:** E.H.R **Outcome Improvement Target 1 Estimated Incentive Payment:** $15,349	**Outcome Improvement Target** 1:IT3 3.2 Congestive Heart Failure 30 day readmission rate **Metric**: Reduce CHF readmission rate by 10% over baseline Goal: 10% reduction in CHF readmission rate over baseline **Data Source:** E.H.R **Outcome Improvement Target 1 Estimated Incentive Payment:** $25,092	**Outcome Improvement Target** 1:IT3 3.2 Congestive Heart Failure 30 day readmission rate **Metric**: Reduce CHF readmission rate by 20% over baseline Goal: 20% reduction in CHF readmission rate over baseline **Data Source:** E.H.R **Outcome Improvement Target 1 Estimated Incentive Payment:** $60,433

131037704. 3.4	*3.4 IT-3.2*	Potentially Preventable Re-Admissions-30 Day Admission Rates	
Hopkins County Memorial Hospital			131037704
Related Category 2 Project:	131037704.2.2		
Starting Point/Baseline:	Baseline TBD in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
system Goal: Baseline established **Data Source**: E.H.R **Process Milestone 3 Estimated Incentive Payment:** $4314.66			
Year 2 Estimated Outcome Amount: $12,944	Year 3 Estimated Outcome Amount: $15,349	Year 4 Estimated Outcome Amount: $25,092	Year 5 Estimated Outcome Amount: $60,433
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $113,818			

Outcome Measure (Improvement Target): IT-1.6 – Cholesterol Management for Patients with Cardiovascular Conditions NCQA-HEDIS 2012
Unique Project ID: 131038504.3.1
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Outcome Measure Description:
To demonstrate improved access to primary care Hunt Regional Medical Center has selected Improvement Target 1.6, cholesterol management for patients with cardiovascular conditions. The selected *process milestones* include:

- Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Project planning will be demonstrated by an implementation plan to improve cholesterol management in patients with cardiovascular conditions specifying baseline rates, data systems, performance improvement and dissemination of plan to stakeholders.
- Establishing baseline rates to determine current cholesterol screening and LDL average value in the target primary care population.
- Develop and test data systems to collect and measure required data points.
- Conduct performance improvement activities with the plan, do, study, act model to ensure reliable screening, treatment and reporting activities.
- Disseminate findings to stakeholders, including lessons learned and best practices in a report format.

The outcome improvement targets reflect both screening for the presence of hyperlipidemia and treating low-density lipoprotein to goal levels. The improvement target baseline will be determined during demonstration year 2. The *outcome improvement targets* include:

- Measuring the percent of patients with cardiovascular disease who received a low-density lipoprotein screening.
- Measuring the percent of patients with cardiovascular disease who had a low-density lipoprotein level less than 100mg/dL during the previous measurement year.

Rationale:
The goal in expanding primary care capacity is to improve primary, preventative care that will improve patient outcomes and reduce morbidity. HRMC selected cholesterol management for patients with cardiovascular disease because this outcome improvement target specifically measures the impact of increasing primary care capacity. The Texas Department of State Health Services estimates that the African American, Hispanic, and Caucasian population in East Texas have lower cholesterol screening rates than the state as a whole. According to DSHS, 83.5% of the Hispanic population in East Texas has not had their cholesterol checked within the last five years, compared to 57.5% of the statewide Hispanic population. For African Americans in East Texas, 45.3% have not had a cholesterol screening in the last five years, compared with 26.1% of the statewide African American population. 28.3% of Caucasians in East Texas had not had a cholesterol screening in five years, compared with 22.4% of the statewide Caucasian population (Texas Department of State Health Services, 2007). Also, as identified in our community needs assessment, Region 1 has a higher than average rate of chronic conditions including cardiovascular disease (CN. 3). In addition, cholesterol is directly related to the development of cardiovascular disease which remains the leading cause of death in the United States. Cholesterol screening and reducing cholesterol directly reduces the occurrence of cardiovascular disease complications including heart attack, peripheral artery disease and stroke (U.S. Preventive Services Task Force, 2008). As hyperlipidemia does not have any symptoms, screening for and treating high cholesterol is critical.

The disenfranchised, low-income population often does not seek primary care until a health event has already occurred. Therefore, increasing access to primary care and managing hyperlipidemia will improve health outcomes in low-income populations. The improvement target baseline will be determined during demonstration year 2.

Outcome Measure Valuation:
The valuation approach for outcome improvement target 'cholesterol management for patients with cardiovascular conditions' is directly related to the valuation for increasing primary care capacity. The valuation is based on the lack of primary care infrastructure, the urgent need and the cost of development. Hunt County has approximately 32,234 underserved individuals and 16,081 unduplicated Medicaid clients according to the Texas Department of State Health Services (2010). In 2011, the HRMC Emergency Department had 5,899 Level 1, 2, 3 visits which could be appropriate in the primary care setting. Additionally, the town of Quinlan in Southern Hunt County has a severe primary care provider shortage.

To improve cholesterol management for patients with cardiovascular conditions and address the primary care deficit, we propose to expand an existing primary care clinic in Greenville and add an additional primary care site in Quinlan. Based on statistics from our FQHC partner, one primary care provider can manage 4,800 encounters/year. The proposed valuation is based on adding two mid-level providers, a medical director, nurse/case managers, support staff, operational expenses, exam equipment, laboratory services, drugs and a renovation of an existing Quinlan medical office owned by Hunt Memorial Hospital District.

References:
Texas Department of State Health Services, 2010, Health Currents. Available at: http://www.dshs.state.tx.us/chs/healthcurrents/

U.S. Preventive Services Task Force. Screening for lipid disorders in adults: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jun. 13. Available at: http://www.uspreventiveservicestaskforce.org/uspstf08/lipid/lipidrs.htm

Process Milestones/Outcome Improvement Target Table

Unique Category 3 outcome measure identifier: 131038504.3.1	Outcome Measure : IT- 1.6	Outcome Measure: Cholesterol management for patients with cardiovascular conditions	
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.1		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve cholesterol management in patients with cardiovascular conditions Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan Baseline/Goal: Identification of process/steps to implement improvement target. Rationale: The infrastructure will need to be planned and built to implement and measure quality outcomes. Milestone 1 Estimated Incentive Payment: $59,503.67 **Milestone 2 [P-2]** Establish baseline rates.	**Milestone 4 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1 [P-4.1]: Conduct performance improvement activities with PDSA model to ensure reliable screening, treatment and reporting activities. Data Source: Documentation/Report of PDSA cycle Baseline/Goal: Performance improvement to meet improvement target. Rationale: Performance improvement is necessary to implement best practices and refine processes. Milestone 4 Estimated Incentive Payment: $103,459 **Milestone 5 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders	**Outcome Improvement Target 1** [IT-1.6]: Improvement Target: Cholesterol management for patients with cardiovascular conditions Numerator: Number of patients who had each of the following during the reporting period. • Low-density Lipoprotein Cholesterol Screening: An LDL-C test performed during the measurement year. • LDL-C level less than 100mg/dL: The most recent LDL-C level during the measurement year is less than 100mg/dL. Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), Coronary Artery Bypass Graft (CABG) or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease	**Outcome Improvement Target 2** [IT-1.6]: Improvement Target: Cholesterol management for patients with cardiovascular conditions Numerator: Number of patients who had each of the following during the reporting period. • Low-density Lipoprotein Cholesterol Screening: An LDL-C test performed during the measurement year. • LDL-C level less than 100mg/dL: The most recent LDL-C level during the measurement year is less than 100mg/dL. Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), Coronary Artery Bypass Graft (CABG) or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease

Unique Category 3 outcome measure identifier: 131038504.3.1	Outcome Measure : IT- 1.6	Outcome Measure: Cholesterol management for patients with cardiovascular conditions	
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.1		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-2.1]: Determine current cholesterol screening and LDL average value in target primary care population. Data Source: EHR/Documentation of baseline cholesterol screening and LDL value levels. Baseline/Goal: Establish baseline to determine improvement target Rationale: It is necessary to measure current performance to plan improvement. Milestone 2 Estimated Incentive Payment: $$59,503.67 **Milestone 3 [P-3]** Develop and test data systems Metric 1 [P-3.1]: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process.	Metric 1 [P-5.1]: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation Baseline/Goal: Educate stakeholders on quality outcome initiative /processes. Rationale: Stakeholder engagement is necessary to maintain best practices. Milestone 5 Estimated Incentive Payment: $103,459	(IVD) during the measurement year and the year prior to the measurement year. Baseline/Goal: TBD Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $332,031	(IVD) during the measurement year and the year prior to the measurement year. Baseline/Goal: TBD Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $793,987

Unique Category 3 outcome measure identifier: 131038504.3.1	Outcome Measure : IT- 1.6	Outcome Measure: Cholesterol management for patients with cardiovascular conditions	
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.1		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: Establish data collection process needed to measure population, cholesterol screening and LDL result Rationale: Testing the process to screen, treat and report necessary data points are necessary to validate data. Milestone 3 Estimated Incentive Payment: $59,503.67			
Year 2 Estimated Outcome Amount:: $178,511	Year 3 Estimated Outcome Amount: $206,918	Year 4 Estimated Outcome Amount: $332,031	Year 5 Estimated Outcome Amount: $793,987
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $1,511,447			

Outcome Measure (Improvement Target): IT-9.2 – ED Appropriate Utilization
Unique Project ID: 131038504.3.2
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Outcome Measure Description:
The objective of patient navigation is to facilitate and support patients navigate through the continuum of healthcare services providing patients with coordinated, timely care. To demonstrate improved patient health outcomes and experience while decreasing costs, Hunt Regional Medical Center has selected Improvement Target- 9.2, ED appropriate utilization. The selected *process milestones* include:

- Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Project planning will be demonstrated by an implementation plan to improve ED appropriate utilization.
- Establish baseline rates to determine current total ED utilization rates.
- Develop and test data systems to collect and measure required data points.
- Conduct performance improvement activities with the plan, do, study, act model to review ED utilization reduction interventions.
- Disseminate findings to stakeholders, including lessons learned and best practices in a report format.

The *outcome improvement* target includes reducing all ED visits. The improvement target baseline will be determined during demonstration year 2.

Rationale:
As identified in our Community Needs Assessment, RHP 1 has significant healthcare delivery barriers including deficits in primary care (CN. 1), higher than average occurrence of chronic illnesses (CN. 3) and an increasing uninsured population. All of these barriers result in non-emergent ED visits (CN. 5). We selected this improvement target because it specifically measures the project objective of reduced ED utilization. We have selected milestones and metrics for this project to measure progress in developing a plan to reduce overall ED visits. The improvement target baseline will be determined during demonstration year 2.

Outcome Measure Valuation:
According to the Institute for Healthcare Improvement (Craig, Eby and Whittington, 2011), people with multiple health and social needs have better outcomes and experience in the most appropriate setting when they have ongoing care coordination to support complex health needs. The patient navigation valuation approach included accounting for the significant large scope of the project and the healthcare delivery barriers of: increasing rates of un-insured patients, primary care deficits/underutilization (CN. 1), increased chronic illness (CN. 3) and increasing non-emergent ED encounters (CN. 5). This project also works in tandem with the primary care and care transitions projects to improve patient outcomes while reducing preventable admissions, readmissions, complications and Emergency Department utilization. The cost associated with this project includes: (1) hiring and training patient navigator staff, (2) transportation for home visits and to healthcare appointments, (3) patient supplies and mediation and (4) an electronic medical record tool to track and monitor patients.

References:

Craig C, Eby D, Whittington J. (2011). *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Institute for Healthcare Improvement. Available at: http://www.ihi.org/knowledge/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Process Milestones/Outcome Improvement Target Table

Unique Category 3 outcome measure identifier: 131038504.3.2	Outcome Measure : IT- 9.2	Outcome Measure: ED appropriate utilization	
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.2.1		
Starting Point/Baseline:	HRMC fiscal year 2011- 44,459 total ED visits Additional pediatric and disease specific baseline to be determined during Demonstration Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. <u>Metric 1 [P-1.1]:</u> Develop an implementation plan to improve ED appropriate utilization. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan Baseline/Goal: Identification of process/steps to implement improvement target. Rationale: The infrastructure will need to be planned and built to implement and measure quality outcomes. Milestone 1 Estimated Incentive Payment: $76,779 **Milestone 2 [P-2]** Establish baseline rates. <u>Metric 1 [P-2.1]:</u> Determine current total ED utilization	**Milestone 4 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. <u>Metric 1 [P-4.1]:</u> Conduct performance improvement activities with PDSA model to review ED utilization reduction interventions Data Source: Documentation/Report of PDSA cycle Baseline/Goal: Performance improvement to meet improvement target. Rationale: Performance improvement is necessary to implement best practices and refine processes. Milestone 4 Estimated Incentive Payment: $133,495 **Milestone 5 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders <u>Metric 1 [P-5.1]:</u> Evaluate implementation plan, baseline	**Outcome Improvement Target 1** IT-9.2 Improvement Target: ED appropriate utilization Reduce all ED visits (including ACSC) Baseline/Goal: TBD Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $428,427	**Outcome Improvement Target 2** IT-9.2 Improvement Target: ED appropriate utilization Reduce all ED visits (including ACSC) Baseline/Goal: TBD Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $1,024,499

Unique Category 3 outcome measure identifier: 131038504.3.2	Outcome Measure : IT- 9.2	Outcome Measure: ED appropriate utilization	
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.2.1		
Starting Point/Baseline:	HRMC fiscal year 2011- 44,459 total ED visits Additional pediatric and disease specific baseline to be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
rates. Data Source: EHR/Documentation of baseline ED utilization rates Baseline/Goal: Establish baseline to determine improvement target. Rationale: It is necessary to measure current performance to plan improvement. Milestone 2 Estimated Incentive Payment: $76,779 **Milestone 3 [P-3]** Develop and test data systems <u>Metric 1 [P-3.1]:</u> Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure ED utilization rates. Rationale: Testing the process to collect	rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation Baseline/Goal: Educate stakeholders on quality outcome initiatives/ processes to reduce ED utilization. Rationale: Stakeholder engagement is necessary to maintain best practices. Milestone 5 Estimated Incentive Payment: $133,495		

Unique Category 3 outcome measure identifier: 131038504.3.2	Outcome Measure : IT- 9.2	Outcome Measure: ED appropriate utilization	
RHP Performing Provider: Hunt Regional Medical Center Greenville			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.2.1		
Starting Point/Baseline:	HRMC fiscal year 2011- 44,459 total ED visits Additional pediatric and disease specific baseline to be determined during Demonstration Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
data points is necessary to validate data. Milestone 3 Estimated Incentive Payment: $76,779			
Year 2 Estimated Outcome Amount: $230,337	Year 3 Estimated Outcome Amount: $266,990	Year 4 Estimated Outcome Amount: $428,427	Year 5 Estimated Outcome Amount: $1,024,499
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $1,950,253			

Outcome Measure (Improvement Target): IT-3.1 – All Cause 30 Day Readmission Rate NQF 1789
Unique Project ID: 131038504.3.3
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Outcome Measure Description:
Expanding care transitions is expected to result in improved patient outcomes and reduced hospital readmissions. To demonstrate improved outcomes with fewer readmissions, Hunt Regional Medical Center has selected Improvement Target- 3.1, all cause 30 day readmission rate. The selected *process milestones* include:

- Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Project planning will be demonstrated by an implementation plan to reduce all cause 30 day readmissions.
- Establish baseline rates of all cause 30 day readmission rates.
- Develop and test data systems to collect and measure required data points.
- Conduct performance improvement activities with the plan, do, study, act model to review readmission reduction interventions.
- Disseminate findings to stakeholders, including lessons learned and best practices in a report format.

The *outcome improvement* target includes reducing all cause 30 day readmission rates. The improvement target baseline will be determined during demonstration year 2.

Rationale:
HRMC selected this improved target because reducing preventable readmissions reflects success expanding care transitions. Reducing preventable readmissions is a regional priority because reducing readmissions reflects improved chronic care management (CN. 3) and effective healthcare delivery (CN.6). We have selected milestones and metrics for this project to capture success in redesigning the discharge process to foster a smooth, coordinated transition from the inpatient setting to home that will result in a reduction in readmissions. The improvement target baseline will be determined during demonstration year 2.

Outcome Measure Valuation:
In a recent study published in the Annuals of Internal Medicine, implementing a standardized, comprehensive discharge reduced subsequent hospital utilization by 30% including hospital readmissions and Emergency Department visits (Jack et al., 2009). The care transitions valuation approach included accounting for the importance of providing a smooth transition process that is foundational to outpatient care. We selected this project because it works in conjunction with the primary care and patient navigation projects to improve patient outcomes while reducing preventable admissions, readmissions, complications and Emergency Department utilization. Additionally, based on CMS discharge data the HRMC 30 day readmission rates during the baseline period of July 1, 2008- June 30, 2011 were higher than national averages. HRMC's acute myocardial infarction 30 day readmission rate was 22.3% compared to the national average of 19.8%. HRMC's heart failure 30 day readmission rate was 25.7% compared to the national average of 24.8% and HRMC's pneumonia 30 day readmission rate was 19.4% compared to 18.4% nationally. The cost associated with this project includes hiring and training discharge advocates, care transition tools and discharge instruction (Project RED) software.

References:
Jack, B., et al. (2009). A reengineered hospital discharge program to reduce Rehospitalizations. *Annuals of Internal Medicine,* 150:178-187. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738592/

Unique Category 3 outcome measure identifier: 131038504.3.3	Outcome Measure : IT-3.1	Outcome Measure: All cause 30 day readmission rate	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.2.2		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. <u>Metric 1 [P-1.1]:</u> Develop an implementation plan to reduce all cause 30 day readmissions. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline/Goal: Identification of process/steps to implement improvement target. Rationale: The infrastructure will need to be planned and built to implement and measure quality outcomes. Milestone 1 Estimated Incentive Payment: $22,074 **Milestone 2 [P-2]** Establish baseline rates. <u>Metric 1 [P-2.1]:</u> Determine current 30 day readmission	**Milestone 4 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. <u>Metric 1 [P-4.1]:</u> Conduct performance improvement activities with PDSA model to improve reducing readmission interventions. Data Source: Documentation/Report of PDSA cycle Baseline/Goal: Performance improvement to meet improvement target. Rationale: Performance improvement is necessary to implement best practices and refine processes. Milestone 4 Estimated Incentive Payment: $38,380 **Milestone 5 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders <u>Metric 1 [P-5.1]:</u> Evaluate implementation plan, baseline rates, data collection and performance	**Outcome Improvement Target 1** IT-3.1: Improvement Target: All cause 30 day readmission rate a. Numerator: The outcome for this measure is unplanned all cause 30 day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: Admissions to acute care facilities for patients aged 18 years or older. Baseline/Goal: TBD Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $123,173	**Outcome Improvement Target 2** IT-3.1: Improvement Target: All cause 30 day readmission rate a. Numerator: The outcome for this measure is unplanned all cause 30 day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b. Denominator: Admissions to acute care facilities for patients aged 18 years or older. Baseline/Goal: TBD Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment: $294,543

Unique Category 3 outcome measure identifier: 131038504.3.3	Outcome Measure : IT-3.1	Outcome Measure: All cause 30 day readmission rate	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.2.2		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
rates. Data Source: EHR/Documentation of baseline readmission rates Baseline/Goal: Establish baseline to determine improvement target. Rationale: It is necessary to measure current performance to plan improvement. Milestone 2 Estimated Incentive Payment: $22,074 **Milestone 3 [P-3]** Develop and test data systems. <u>Metric 1 [P-3.1]:</u> Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure all cause 30 day readmission rates. Rationale: Testing data collection	improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation Baseline/Goal: Educate stakeholders on quality outcome initiatives/ processes. Rationale: Stakeholder engagement is necessary to maintain best practices. Milestone 5 Estimated Incentive Payment: $38,380		

Unique Category 3 outcome measure identifier: 131038504.3.3	Outcome Measure : IT-3.1	Outcome Measure: All cause 30 day readmission rate	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.2.2		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
process is necessary to validate data. Milestone 3 Estimated Incentive Payment: $22,074			
Year 2 Estimated Outcome Amount: $66,222	Year 3 Estimated Outcome Amount: $76,760	Year 4 Estimated Outcome Amount: $123,173	Year 5 Estimated Outcome Amount: $294,543
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $560,698			

Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 Day Readmission Rate
Unique Project ID: 131038504.3.4
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Outcome Measure Description:
Introducing telehealth to provide intense case management and remote patient monitoring in the congestive heart failure population is expected to result in improved patient outcomes and experience with reduced healthcare costs and hospital readmissions. To demonstrate improved outcomes with fewer readmissions, Hunt Regional Medical Center has selected Improvement Target- 3.2, Congestive Heart Failure 30 day readmission rate.

The selected *process milestones* include:

- Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Project planning will be demonstrated by an implementation plan to reduce congestive heart failure 30 day readmissions.
- Establish baseline congestive heart failure 30 day readmission rates.
- Develop and test data systems to collect and measure required data points.
- Conduct performance improvement activities with the plan, do, study, act model to guide readmission reduction interventions.
- Disseminate findings to stakeholders, including lessons learned and best practices in a report format.

The *outcome improvement* target includes reducing congestive heart failure 30 day readmission rates. The improvement target baseline will be determined during demonstration year 2.

Rationale:
We have focused on the congestive heart failure population because heart failure is the leading cause of hospital readmission with almost 30% of heart failure admissions readmitted with 30 days (Lloyd-Jones, et al., 2010). The objective of telehealth program is to provide remote patient monitoring and disease management to congestive heart failure patients to improve heart failure management and reduce hospital readmissions. According to the Institute for Healthcare Improvement (Amoah, B., et. al., 2008), enhanced outpatient multidisciplinary services have shown to reduce mortality by up to 20 percent and heart failure readmissions by 33 percent. We have selected this outcome improvement target because:

- Congestive heart failure is the specific target population of the proposed telehealth project
- Readmissions are a reliable and valid quality indictor of outpatient management
- Heart failure is a chronic, progressive, complex disease that requires intense outpatient management to avoid exacerbation.
- Hunt County residents have a higher than average occurrence of chronic illnesses including cardiovascular disease (CN. 3)

The improvement target baseline will be determined during demonstration year 2.

Outcome Measure Valuation:
In a pioneering study published in *The New England Journal of Medicine,* Jencks, Williams and Coleman (2009) discovered alarming statistics on the scope of hospital readmissions. Almost 20% of Medicare beneficiaries are readmitted to the hospital within 30 days from the index admission with 70% of these readmissions having a chronic medical condition. Furthermore, 50% of the readmissions did not have a claim for outpatient care, illustrating the fundamental lack of continuity of care. The cost of 1 in 5 unplanned hospital readmissions is estimated at 17.4 billion dollars per year. Additionally, we have focused on the congestive heart failure

population because heart failure is the leading cause of hospital readmission with almost 30% of heart failure admissions readmitted with 30 days (Lloyd-Jones, et al., 2010).

There is consensus in the medical literature, that telehealth results in improved patient outcomes, experience and morbidity/mortality with reduced hospitalizations and readmissions. The approach to valuation of the CHF readmission outcome measure is based on the need for rapid infrastructure development to address:

- A growing chronic disease population in Hunt County and RHP 1 (CN. 1)
- The overwhelming benefit of intensely managing patients with chronic illnesses in the outpatient setting
- The connectivity with other Hunt Regional Medical Center transformation projects including primary care, patient navigation and improving care transitions
- The cost of telehealth including: telehealth nursing and office staff for remote monitoring and home visits, an advanced practice nurse for outpatient management and treatment, self-management patient education and materials and tele-monitoring equipment

References:

Amoah, B., Boutwell, A., Schall, M., Sevin, C., Shapiro, E., & Taylor, J. (2008). Getting started guide improving care for patients with heart failure: Focus on ambulatory care. Institute for Healthcare Improvement. Available at: http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Tools/GettingStartedGuideImprovingCareHeartFailureAmbulatoryCare.htm

Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the medicare fee-for-service program. *The New England Journal of Medicine, 360*(14), 1418-1428. Available at: http://www.commonwealthfund.org/Publications/In-the-Literature/2009/Apr/Rehospitalizations-Among-Patients-in-the-Medicare-Fee-for-Service.aspx

Lloyd-Jones, D., Adams, R. J., Brown, T. M., Carnethon, M., Dai, S., De Simone, G., . . . Wylie-Rosett, J. (2010). Heart disease and stroke statistics--2010 update: A report from the American heart association. *Circulation, 121*(7), e46-e215. Available at: http://circ.ahajournals.org/content/121/7/948.full

Process Milestones/Outcome Improvement Target Table

Unique Category 3 outcome measure identifier: 131038504.3.4	Outcome Measure : IT-3.2	Outcome Measure: Congestive heart failure 30 day readmission rate	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.2		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to reduce congestive heart failure 30 day readmissions. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline/Goal: Identification of process/steps to implement improvement target. Rationale: The infrastructure will need to be planned and built to implement and measure quality outcomes. Milestone 1 Estimated Incentive Payment: $ 12,842 **Milestone 2 [P-2]** Establish baseline rates.	**Milestone 4 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1 [P-4.1]: Conduct performance improvement activities with PDSA model to improve reducing readmission interventions. Data Source: Documentation/Report of PDSA cycle Baseline/Goal: Performance improvement to meet improvement target. Rationale: Performance improvement is necessary to implement best practices and refine processes. Milestone 4 Estimated Incentive Payment: $ 22,841 **Milestone 5 [P-5]** Disseminate findings, including lessons learned and best practices to stakeholders. Metric 1 [P-5.1]: Evaluate implementation plan, baseline	**Outcome Improvement Target 1 IT-3.2:** Improvement Target: Congestive Heart Failure 30 day readmission rate a. Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as a readmission. b. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. Baseline/Goal: TBD Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $ 74,682	**Outcome Improvement Target 2 IT-3.2:** Improvement Target: Congestive Heart Failure 30 day readmission rate a. Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as a readmission. b. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. Baseline/Goal: TBD Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment: $ 179,867

Unique Category 3 outcome measure identifier: 131038504.3.4	Outcome Measure : IT-3.2	Outcome Measure: Congestive heart failure 30 day readmission rate	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.2		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-2.1]: Determine current congestive heart failure 30 day readmission rates. Data Source: EHR/Documentation of baseline readmission rates Baseline/Goal: Establish baseline to determine improvement target. Rationale: It is necessary to measure current performance to plan improvement. Milestone 2 Estimated Incentive Payment: $ 12,842 **Milestone 3 [P-3]** Develop and test data systems. Metric 1 [P-3.1]: Develop and test system to collect and measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure congestive heart failure 30 day readmission rates.	rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation Baseline/Goal: Educate stakeholders on quality outcome initiatives/ processes. Rationale: Stakeholder engagement is necessary to maintain best practices. Milestone 5 Estimated Incentive Payment: $ 22,841		

Unique Category 3 outcome measure identifier: 131038504.3.4	Outcome Measure : IT-3.2	Outcome Measure: Congestive heart failure 30 day readmission rate	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.2		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Rationale: Testing data collection process is necessary to validate data. Milestone 3 Estimated Incentive Payment: $ 12,842			
Year 2 Estimated Outcome Amount: $ 38,526	Year 3 Estimated Outcome Amount: $ 45,682	Year 4 Estimated Outcome Amount: $ 74,682	Year 5 Estimated Outcome Amount: $ 179,867
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $ 338,757			

Outcome Measure (Improvement Target): IT-4.1 Improvement in risk adjusted Potentially Preventable Complications rate(s)
Unique Project ID: 131038504.3.5
Performing Provider Name/TPI: Hunt Regional Medical Center Greenville/131038504

Outcome Measure Description:
Enhanced performance improvement and reporting capacity is expected to reduce potentially preventable complications. To demonstrate improved health outcomes and experience while decreasing costs, Hunt Regional Medical Center has selected Improvement Target IT-4.1 Improvement in the risk adjusted Potentially Preventable Complications rate(s).

The selected *process milestones* include:

- Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Project planning will be demonstrated by an implementation plan to reduce potentially preventable complications rate(s).
- Establish baseline potentially preventable complications rate(s).
- Develop and test data systems to collect and measure required data points.
- Conduct performance improvement activities with the plan, do, study, act model to guide complications reduction interventions.
- Disseminate findings to stakeholders, including lessons learned and best practices in a report format.

The *outcome improvement* target includes the percent change in the top 5 of the 10 highest volume risk adjusted potentially preventable complications rates. The improvement target baseline will be determined during demonstration year 2.

Rationale:
Potentially preventable complications are an often preventable and unexpected result of hospitalization that was not present on admission (Fuller, McCullough, Bao and Averill, 2009). Focusing performance improvement activities on high risk, high occurrence complications will have a profound effect on improving care delivery safety and effectiveness. Reduced complications result in improved patient outcomes, mortality and patient experience, reduced length of stay, resource utilization and cost.

We have selected Improvement in the risk adjusted Potentially Preventable Complications rates because:

- Reducing complications and healthcare acquired conditions are a direct health outcome indicator of the objective of the performance improvement and reporting capacity project to improve the quality of care at Hunt Regional Medical Center to deliver safe, effective, timely, patient-centered, equitable and efficient care.
- Hunt County ranks 155 out of 221 counties for health indicators in Texas (County Health Rankings and Roadmaps, 2012).
- The Hunt County premature death rate for persons who died younger than age 75 is 10,114/100,000 population compared to a state average of 7,186/100,000 (County Health Rankings and Roadmaps, 2012).
- Region 1 has higher rates of chronic illness compared to state averages including diabetes, cardiovascular disease, obesity and cancer (Texas Department of State Health Services, 2007).
- Texas ranked 49th out of the 50 states plus the District of Columbia in the Commonwealth Fund's 2007 State Scorecard on Health System Performance.

- The indigent and Medicaid population is more likely to access healthcare in the acute care setting versus outpatient, primary care. Overall, the low income population also receives less preventative care, be diagnosed at a more advanced stage of disease and receive less therapeutic care than the insured population (Code Red, 2006). Reducing complications will improve health disparities experienced by the low income population.

The improvement target baseline will be determined during demonstration year 2.

Outcome Measure Valuation:
Potentially preventable complications are estimated to add nine percent to hospital inpatient costs, resulting in an approximately $88 billion dollar cost for the nation (Fuller, McCullough, Bao and Averill, 2009). Complications and hospital acquired conditions also result in patient harm, increased length of stay and increased morbidity and mortality. There is consensus in the medical literature that performance improvement centered on the Institute of Medicine's six aims of providing safe, effective, timely, patient-centered, equitable and efficient care will add value to healthcare resulting in improved outcomes and patient experience at a reduced cost.

The approach to valuation for the potentially preventable complications outcome measure is based on the need for rapid infrastructure development to address:

- Efficiency in and effectiveness of health care delivery (CN. 6).
- The overwhelming benefit of performance improvement to provide consistent, evidence based care to improve quality and safety.
- The connectivity with other Hunt Regional Medical Center transformation projects including primary care, tele health, patient navigation and improving care transitions.
- Enhancing performance improvement and reporting capacity is necessary to assess and act on the causality of healthcare disparities in the chronic condition population (CN. 3).
- The cost of enhanced performance improvement and reporting capacity including: the purchase of an electronic medical record interface and data repository, data analysts to support the technology and clinical analysts to apply the data to performance improvement activities.

References:
The Commonwealth Fund Commission on a High Performance Health System. (2008). Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008.
Available at:
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2008/Jul/Why%20Not%20the%20Best%20%20Results%20from%20the%20National%20Scorecard%20on%20U%20S%20%20Health%20System%20Performance%20%202008/Why_Not_the_Best_national_scorecard_2008%20pdf.pdf

Fuller, R., McCullough, E., Bao, M., Averill, R. (2009). Estimating the costs of potentially preventable hospital acquired complications. Healthcare financing reviews. 30:4. Available at:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2914724/

Institute of Medicine, Committee on Quality of Health Care in America. Crossing the Quality Chasm—A New Health System for the 21st Century. Washington, DC: National Academy Press, 2001. Available at:
http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

Population Health Institute at the University of Wisconsin, County Health Rankings and Roadmaps, 2012. Available at: http://www.countyhealthrankings.org/#app/texas/2012/hunt/county/1/overall

Task Force for Access to Health Care in Texas. (2006). Code Red. The Critical Condition of Health in Texas. Available at:
http://www.coderedtexas.org/

Texas Department of State Health Services. (2007). *East Texas Community Health Needs Assessment.* Austin: State of Texas.

Unique Category 3 outcome measure identifier: 131038504.3.5	Outcome Measure : IT-4.1	Outcome Measure: Improvement in risk adjusted Potentially Preventable Complications rate(s)	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.3		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. <u>Metric 1 [P-1.1]:</u> Develop an implementation plan to reduce potentially preventable complications. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. Baseline/Goal: Identification of process/steps to implement improvement target. Rationale: The infrastructure will need to be planned and built to implement and measure quality outcomes. Milestone 1 Estimated Incentive Payment: $ 8700.34	**Milestone 4 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. <u>Metric 1 [P-4.1]:</u> Conduct performance improvement activities with PDSA model to improve reducing potentially preventable complications. Data Source: Documentation/Report of PDSA cycle Baseline/Goal: Performance improvement to meet improvement target. Rationale: Performance improvement is necessary to implement best practices and refine processes. Milestone 4 Estimated Incentive Payment: $ 15,474.50 **Milestone 5 [P-5]** Disseminate findings, including lessons learned and best practices to	**Outcome Improvement Target 1 IT-4.1:** Improvement Target: Improvement in risk adjusted Potentially Preventable Complications rate(s) Numerator: Percent change in risk adjusted PPC rate for targeted conditions. Select 5 from the list of 10 highest volume complications or the list of complications with rates higher than the state rate. Report on percent improvement in the selected 5 measures. Baseline/Goal: TBD Data Source: TX PPC report, EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $ 50,596	**Outcome Improvement Target 2 IT-4.1:** Improvement Target: Improvement in risk adjusted Potentially Preventable Complications rate(s) Numerator: Percent change in risk adjusted PPC rate for targeted conditions. Select 5 from the list of 10 highest volume complications or the list of complications with rates higher than the state rate. Report on percent improvement in the selected 5 measures. Baseline/Goal: TBD Data Source: TX PPC report, EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment: $ 121,857

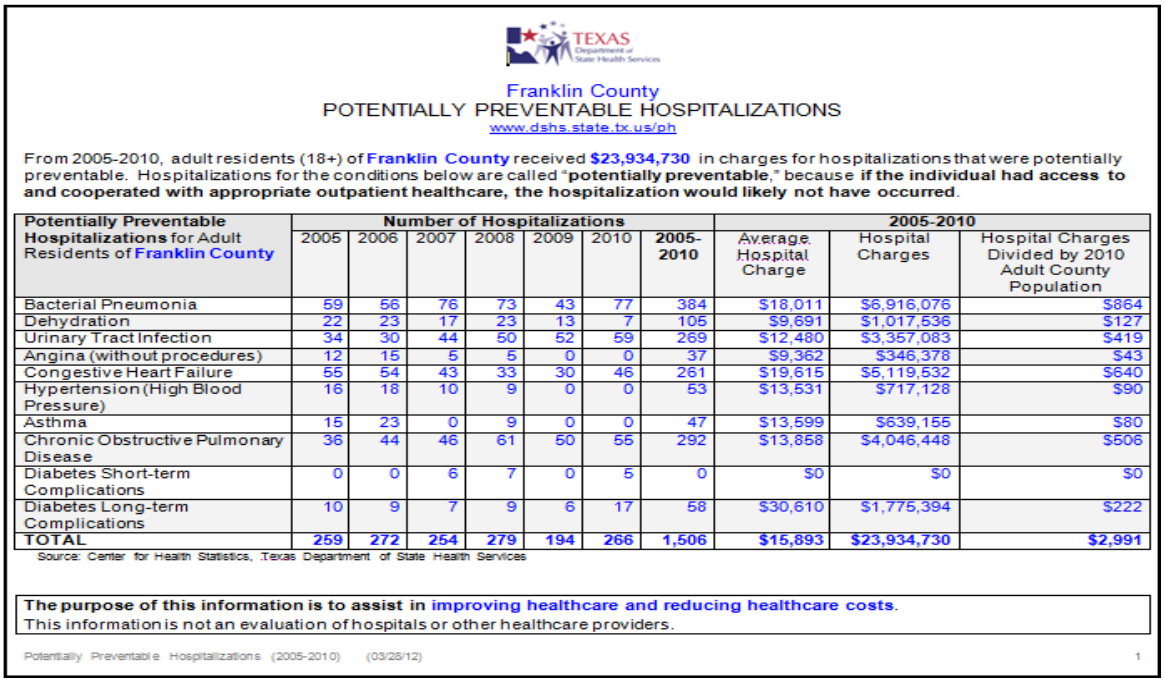
Unique Category 3 outcome measure identifier: 131038504.3.5	Outcome Measure : IT-4.1	Outcome Measure: Improvement in risk adjusted Potentially Preventable Complications rate(s)	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.3		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [P-2] Establish baseline rates. Metric 1 [P-2.1]: Determine current potentially preventable complications rates. Data Source: Documentation of baseline readmission rates based on TX PPC report, EHR, claims data Baseline/Goal: Establish baseline complication rates to determine improvement target. Rationale: It is necessary to measure current performance to plan improvement. Milestone 2 Estimated Incentive Payment: $ 8700.34 **Milestone 3 [P-3]** Develop and test data systems. Metric 1 [P-3.1]: Develop and test system to collect and	stakeholders. Metric 1 [P-5.1]: Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders. Data Source: Documentation/Report of evaluation Baseline/Goal: Educate stakeholders on quality outcome initiatives/ processes. Rationale: Stakeholder engagement is necessary to maintain best practices. Milestone 5 Estimated Incentive Payment: $ 15,474.50		

Unique Category 3 outcome measure identifier: 131038504.3.5	Outcome Measure : IT-4.1	Outcome Measure: Improvement in risk adjusted Potentially Preventable Complications rate(s)	
RHP Performing Provider: Hunt Regional Medical Center			PERFORMING PROVIDER TPI: 131038504
Related Category 1 or 2 Projects:	131038504.1.3		
Starting Point/Baseline:	To be determined during Demonstration Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
measure required data points. Data Source: Documentation/Report of data tests explaining data collection process. Baseline/Goal: Establish data collection process needed to measure potentially preventable complicate rates. Rationale: Testing data collection process is necessary to validate data. Milestone 3 Estimated Incentive Payment: $ 8700.34			
Year 2 Estimated Outcome Amount: $ 26,101	Year 3 Estimated Outcome Amount: $ 30,949	Year 4 Estimated Outcome Amount: $ 50,596	Year 5 Estimated Outcome Amount: $ 121,857
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $ 229,503			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 136140407.3.1
Performing Provider & TPI: ETMC Mt. Vernon 136140407

Outcome Measure Description: ETMC Mt. Vernon's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Franklin County alone there were approximately 1,506 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $23M in charges.



TEXAS Department of State Health Services

Franklin County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Franklin County** received **$23,934,730** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Franklin County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	59	56	76	73	43	77	384	$18,011	$6,916,076	$864
Dehydration	22	23	17	23	13	7	105	$9,691	$1,017,536	$127
Urinary Tract Infection	34	30	44	50	52	59	269	$12,480	$3,357,083	$419
Angina (without procedures)	12	15	5	5	0	0	37	$9,362	$346,378	$43
Congestive Heart Failure	55	54	43	33	30	46	261	$19,615	$5,119,532	$640
Hypertension (High Blood Pressure)	16	18	10	9	0	0	53	$13,531	$717,128	$90
Asthma	15	23	0	9	0	0	47	$13,599	$639,155	$80
Chronic Obstructive Pulmonary Disease	36	44	46	61	50	55	292	$13,858	$4,046,448	$506
Diabetes Short-term Complications	0	0	6	7	0	5	0	$0	$0	$0
Diabetes Long-term Complications	10	9	7	9	6	17	58	$30,610	$1,775,394	$222
TOTAL	**259**	**272**	**254**	**279**	**194**	**266**	**1,506**	**$15,893**	**$23,934,730**	**$2,991**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

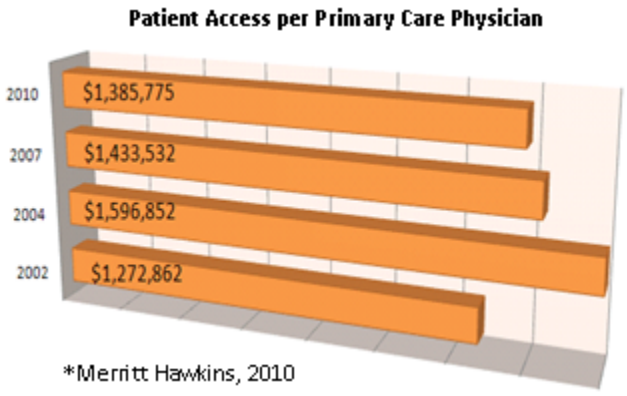
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15%

decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $164,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $146,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		582
ED visits / year / person*		0.45
Potential ED Visits		262
ED Visits Reduced @ 15%		39
Avg ED Payment		$425
ED Savings	**$**	**16,722**
IP Admissions / year / person*		0.11
Potential IP Admissions		66
Admissions Reduced @ 18%		12
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**147,387**
Total Estimated Savings	**$**	**164,109**



136140407.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Mt. Vernon			***136140407***
Related Category 1 or 2 Projects:	***136140407.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $13,545	**Process Milestone 2 Estimated Incentive Payment:** $15,701	**Outcome Improvement Target 1 Estimated Incentive Payment:** $25,194	**Outcome Improvement Target 2 Estimated Incentive Payment:** $60,248
Year 2 Estimated Total DSRIP Funding: $13,545	Year 3 Estimated Total DSRIP Funding: $15,701	Year 4 Estimated Total DSRIP Funding: $25,194	Year 5 Estimated Total DSRIP Funding: $60,248
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$114,689***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 136140407.3.2
Performing Provider & TPI: ETMC Mt. Vernon 136140407

Outcome Measure Description: ETMC Mt. Vernon's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Franklin County alone there were approximately 1,506 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $23M in charges.

TEXAS Department of State Health Services

Franklin County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

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Potentially Preventable Hospitalizations for Adult Residents of **Franklin County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	59	56	76	73	43	77	384	$18,011	$6,916,076	$864
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Asthma	15	23	0	9	0	0	47	$13,599	$639,155	$80
Chronic Obstructive Pulmonary Disease	36	44	46	61	50	55	292	$13,858	$4,046,448	$506
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Diabetes Long-term Complications	10	9	7	9	6	17	58	$30,610	$1,775,394	$222
TOTAL	**259**	**272**	**254**	**279**	**194**	**266**	**1,506**	**$15,893**	**$23,934,730**	**$2,991**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the

clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $150,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $133,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		3,014
% Clinic Appropriate		15%
Clinic Appropriate Patients		452
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**192,319**
Clinic Payment @ 78% savings	$	42,310
Total Estimated Savings	**$**	**150,009**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

136140407.3.2	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Mt. Vernon			***136140407***
Related Category 1 or 2 Projects:	***136140407.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $12,382	**Process Milestone 2 Estimated Incentive Payment:** $14,352	**Outcome Improvement Target 1 Estimated Incentive Payment:** $23,030	**Outcome Improvement Target 2 Estimated Incentive Payment:** $55,071
Year 2 Estimated Total DSRIP Funding: $12,382	Year 3 Estimated Total DSRIP Funding: $14,352	Year 4 Estimated Total DSRIP Funding: $23,030	Year 5 Estimated Total DSRIP Funding: $55,071
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$104,835***			

Outcome Measure (Improvement Target): IT-6.11 Percent Improvement Over Baseline Patient Satisfaction Scores.
Unique RHP Outcome Identification Number: 136367307.3.1
Performing Provider & TPI: Burke Center 136367307

Outcome Measure Description:

Our primary outcome is OD-6 Patient Satisfaction. We have chosen IT6.1.1 to improve patients' satisfaction in receiving timely care, appointments, and information. The expansion of services will meet regional needs but must be done in a manner that meets the satisfaction of the individuals served. The category 3 Process Milestones are designed to enable us to develop an implementation plan; establish baseline rates; and continually improve the process. We plan to improve satisfaction as measured by a standardized survey by targeting areas identified as needing improvement. We will begin this milestone in Year 4.

The process outcomes we chose are P-2 Establish Baseline Rates. This process will require us to acquire a statistically valid patient satisfaction tool which includes a telemedicine component and conduct a sample survey to determine a baseline. This will begin in year 2. This process milestone will lead into the process milestone P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. We will utilize PDSA cycles to address challenges and improve performance until acceptable improvement from baseline is achieved, at a rate to be later determined. We will begin in Year 3.

In addition, Burke Center will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3 based on the valuation studies conducted by health care economists at the University of Texas and the University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Rationale:

Improvements can only be documented when baseline information regarding satisfaction is determined. Continuous improvements will be made as challenges and barriers are identified and successfully addressed.

Outcome Measure Valuation:

One in four people are expected to have a mental illness at some point in their life. Therefore, 25% of our population either has been or will be diagnosed with a mental illness and can be considered as population affected. In addition, the needs assessment morbidity data indicates there is a 76.8% gap in our area based on shortage of mental health providers. Expanding services will reduce this gap. These statistics only emphasize the need to ensure satisfaction with our expansion.

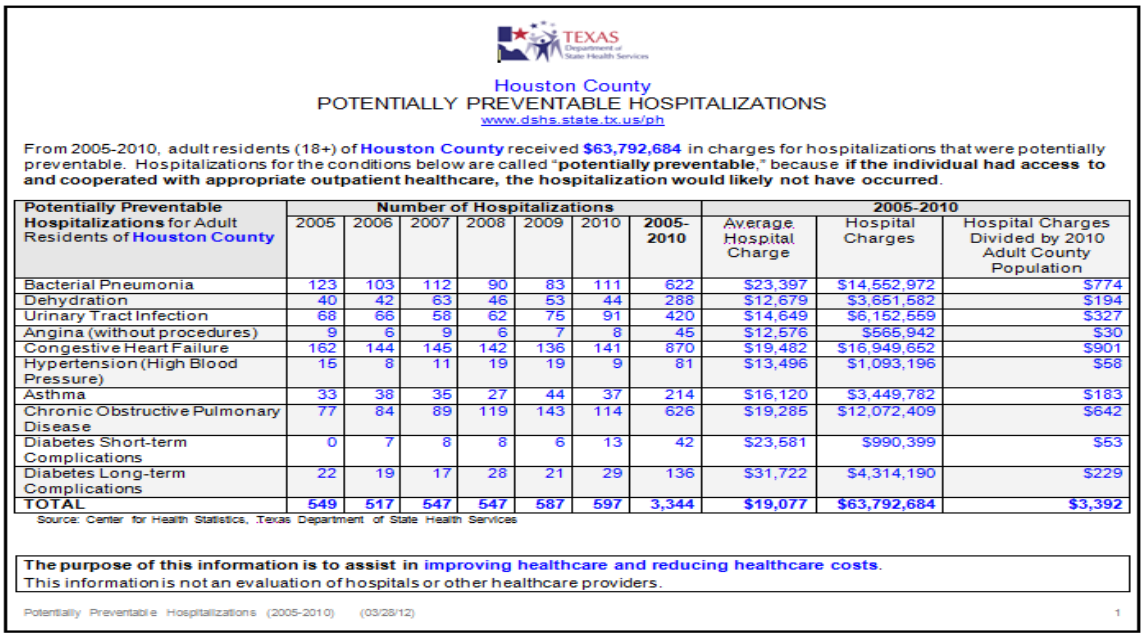
136367307.1.2	*OD-6 IT-6.1*	*Percent improvement over baseline satisfaction scores*	
Burke Center			*136367307*
Related Category 1 or 2 Projects:	***136367307.1.1***		
Starting Point/Baseline:	*Baseline will be the number of Providers current employed and the number of clinic hours in current operation*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: **P-2** Establish baseline rates Metric: Identify current experience of individuals seeking and receiving services regarding timely care, appointments and information. Data source: Appropriate satisfaction survey. Goal: To identify current percentage of rate of access and satisfaction. Rationale: Improvements can only be documented when baseline information regarding satisfaction is determined. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,947	**Process Milestone 2: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities** Metric: Data is collected and analyzed on consumer satisfaction. Data source: Satisfaction surveys, client services in the EHR. Goal: Utilize PDSA cycles to address challenges and improve performance until acceptable improvement from baseline is achieved, at a rate to be later determined. Rationale: Continuous improvements will be made as challenges and barriers are identified and successfully	**Outcome Improvement Target 1:** IT-6.1 Improvement Target: Percent Improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Improvement Target: TBD% improvement over baseline satisfaction scores Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $37,070	**Outcome Improvement Target 2:** IT-6.1: Improvement Target: Percent Improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information. Improvement Target: TBD% improvement over baseline satisfaction scores Outcome Improvement Target 2 Estimated Incentive Payment*:* $80,588

136367307.1.2	*OD-6 IT-6.1*	*Percent improvement over baseline satisfaction scores*	
Burke Center			*136367307*
Related Category 1 or 2 Projects:	***136367307.1.1***		
Starting Point/Baseline:	*Baseline will be the number of Providers current employed and the number of clinic hours in current operation*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	addressed. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 34,653		
Year 2 Estimated Outcome Amount: $14,947	13. Year 3 Estimated Outcome Amount: $34,653	14. Year 4 Estimated Outcome Amount: $37,070	15. Year 5 Estimated Outcome Amount: $80,588
16. TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $167,258			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 137319306.3.1
Performing Provider & TPI: ETMC Crockett 137319306

Outcome Measure Description: ETMC Crockett's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Houston County alone there were approximately 3,344 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $63M in charges.



TEXAS Department of State Health Services

Houston County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Houston County** received **$63,792,684** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Houston County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	123	103	112	90	83	111	622	$23,397	$14,552,972	$774
Dehydration	40	42	63	46	53	44	288	$12,679	$3,651,582	$194
Urinary Tract Infection	68	66	58	62	75	91	420	$14,649	$6,152,559	$327
Angina (without procedures)	9	6	9	6	7	8	45	$12,576	$565,942	$30
Congestive Heart Failure	162	144	145	142	136	141	870	$19,482	$16,949,652	$901
Hypertension (High Blood Pressure)	15	8	11	19	19	9	81	$13,496	$1,093,196	$58
Asthma	33	38	35	27	44	37	214	$16,120	$3,449,782	$183
Chronic Obstructive Pulmonary Disease	77	84	89	119	143	114	626	$19,285	$12,072,409	$642
Diabetes Short-term Complications	0	7	8	8	6	13	42	$23,581	$990,399	$53
Diabetes Long-term Complications	22	19	17	28	21	29	136	$31,722	$4,314,190	$229
TOTAL	549	517	547	547	587	597	3,344	$19,077	$63,792,684	$3,392

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

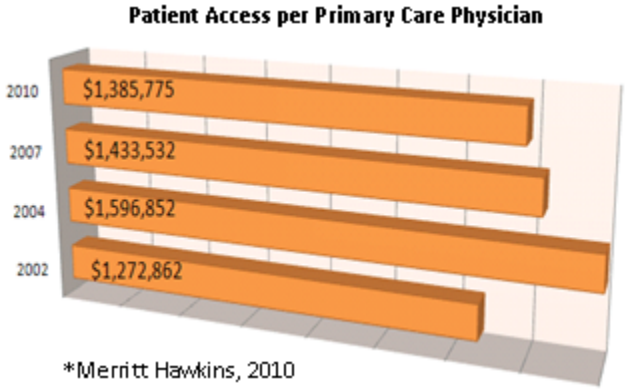
Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $615,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $522,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		2,177
ED visits / year / person		0.45
Potential ED Visits		982
ED Visits Reduced @ 15%		147
Avg ED Payment		$425
ED Savings	**$**	**62,602**
IP Admissions / year / person		0.11
Potential IP Admissions		248
Admissions Reduced @ 18%		45
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**551,781**
Total Estimated Savings	**$**	**614,383**

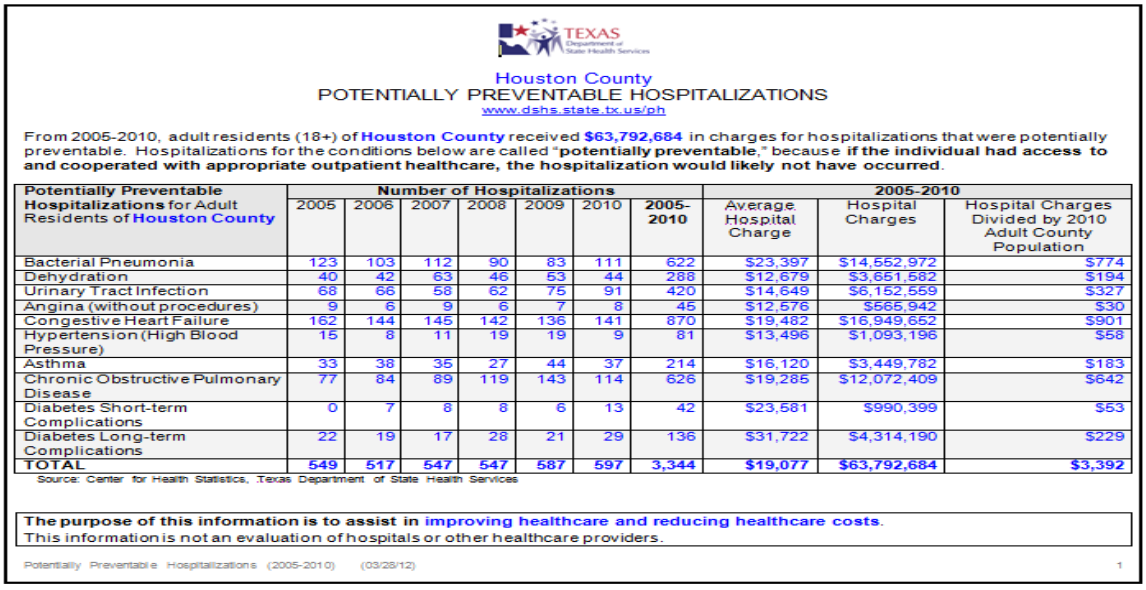


137319306.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Crockett			***137319306***
Related Category 1 or 2 Projects:	***137319306.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $48,395	**Process Milestone 2 Estimated Incentive Payment:** $56,097	**Outcome Improvement Target 1 Estimated Incentive Payment:** $90,015	**Outcome Improvement Target 2 Estimated Incentive Payment:** $215,254
Year 2 Estimated Total DSRIP Funding: $48,395	Year 3 Estimated Total DSRIP Funding: $56,097	Year 4 Estimated Total DSRIP Funding: $90,015	Year 5 Estimated Total DSRIP Funding: $215,254
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$409,761***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 137319306.3.2
Performing Provider & TPI: ETMC Crockett 137319306

Outcome Measure Description: ETMC Crockett's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Houston County alone there were approximately 3,344 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $63M in charges.



TEXAS Department of State Health Services

Houston County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Houston County** received **$63,792,684** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Houston County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	123	103	112	90	83	111	622	$23,397	$14,552,972	$774
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Angina (without procedures)	9	6	9	6	7	8	45	$12,576	$565,942	$30
Congestive Heart Failure	162	144	145	142	136	141	870	$19,482	$16,949,652	$901
Hypertension (High Blood Pressure)	15	8	11	19	19	9	81	$13,496	$1,093,196	$58
Asthma	33	38	35	27	44	37	214	$16,120	$3,449,782	$183
Chronic Obstructive Pulmonary Disease	77	84	89	119	143	114	626	$19,285	$12,072,409	$642
Diabetes Short-term Complications	0	7	8	8	6	13	42	$23,581	$990,399	$53
Diabetes Long-term Complications	22	19	17	28	21	29	136	$31,722	$4,314,190	$229
TOTAL	**549**	**517**	**547**	**547**	**587**	**597**	**3,344**	**$19,077**	**$63,792,684**	**$3,392**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The

relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $690,000 per year. Accordingly, ETMC's average DSRIP funding request of approximately $588,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		13,903
% Clinic Appropriate		15%
Clinic Appropriate Patients		2,085
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**887,130**
Clinic Payment @ 78% savings	$	195,169
Total Estimated Savings	**$**	**691,961**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

137319306.3.2	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Crockett			***137319306***
Related Category 1 or 2 Projects:	***137319306.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $54,506	**Process Milestone 2 Estimated Incentive Payment:** $63,180	**Outcome Improvement Target 1 Estimated Incentive Payment:** $101,382	**Outcome Improvement Target 2 Estimated Incentive Payment:** $242,434
Year 2 Estimated Total DSRIP Funding: $54,506	Year 3 Estimated Total DSRIP Funding: $63,180	Year 4 Estimated Total DSRIP Funding: $101,382	Year 5 Estimated Total DSRIP Funding: $242,434
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$461,502***			

Outcome Measure (Improvement Target): IT-9.2 – ED Appropriate Utilization
Unique RHP Outcome Identification Number: 137921608.3.1
Performing Provider & TPI: Community Healthcore 137921608

Rationale: The critical performance measure for rate of engagement will be important to determine clinical effectiveness of the program, adjustments that need to be made, and if there are lost opportunities to help the patient. Local emergency departments (ED) expend disproportionate resources toward psychiatric admissions that are non-medical in nature. This is a burden that all ED's in the region experience. Ensuring patients are seen at the right place at the right time is critical to increased efficiency and decreased costs.

Outcome Narrative: please address why process milestones and outcome measure were selected. Process milestones chosen include stakeholder engagement that will assist in the development of a plan for sustainability should the projects funding be reduced or eliminated. Similarly, community inclusion for buy-in to the project is important for success in the shift needed in culture of individuals going to the Emergency Department versus the Regional Crisis Response Center (RCRC). A marketing campaign in the community to include the RCRC, local hospitals, local law enforcement and county officials is necessary as a part of the culture change. Capturing the accuracy of the projected admission to actual admissions is important if there are adjustments in the projects. Employing a Plan Do Stud Act (PDSA) cycle will assist in the rapid change processes that will be needed to make the program viable in the midst of change.
Outcome improvement targets were chosen to specifically target individuals that are being seen in the ED with conditions that are not primarily medical in natures. Specifically behavioral health and substance use disorders that are seen in the ED require significant more resources than are necessary for non-medical conditions.

Outcome Measure Valuation: Valuation of the project included cost avoidance with reduced Emergency Department costs for extended stay of individuals that are non-medical in nature, but require a "safe environment". Similarly, an expected reduction of admissions into the hospital through the ED is expected with an increased availability for the hospitals to treat non-psychiatric patients thereby generating revenue by admissions that are in the right place at the right time. An expected reduction of admissions to the state hospital will be achieved through wrap around services and keeping individuals in the community appropriately and preventing loss of work productivity for long periods of absence from the community. Transportation costs for the counties will be reduced and will free law enforcement to return to work "on the streets" for safety issues.

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.1**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-9.2**	*[Outcome Measure (Improvement Target) Title]* **ED appropriate utilization (Standalone measure)**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization. Project Options	~~137921608.1.13~~ 137921608.1.1		
Starting Point/Baseline: 1000/yr			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-Y]: [*Insert specific language for selected process milestone if applicable*] P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Attendance lists & Written Implementation Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $40,694 **Process Milestone 2** P-2: Establish baseline rates: Data Source: 1.Establish base line ED admissions, 2. Establish baseline LOS in ED for psych admissions Process Milestone 2 Estimated	**Process Milestone 3** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: 1. ED admissions, 2. LOS in ED for psych admission Process Milestone 3 Estimated Incentive Payment: $254,797 **Outcome Improvement Target 1** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse Data Source: 1. ED admissions, 2. LOS in ED for psych admission Goal: Decrease ED usage for non-medical admission by 10%. Outcome Improvement Target 1 Estimated Incentive Payment*:* $254,797	**Outcome Improvement Target 2** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse by 10% over baseline Data Source: 1. ED admissions, 2. LOS in ED for psych admission Goal: Decrease ED usage for non-medical admission by 12%. Outcome Improvement Target 3 Estimated Incentive Payment*:* $461,667	**Outcome Improvement Target 3** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse 15% over baseline Data Source: 1. ED admissions, 2. LOS in ED for psych admission Goal: Decrease ED usage for non-medical admission by 15%. Outcome Improvement Target 3 Estimated Incentive Payment*:* $909,499

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.1**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-9.2**	*[Outcome Measure (Improvement Target) Title]* **ED appropriate utilization (Standalone measure)**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization. Project Options	~~137921608.1.13~~ 137921608.1.1		
Starting Point/Baseline: 1000/yr			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment: $40,694			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $81,388	Year 3 Estimated Outcome Amount: $509,594	Year 4 Estimated Outcome Amount: $461,667	Year 5 Estimated Outcome Amount: $909,499
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,962,147			

Outcome Measure (Improvement Target): IT-9.2 – ED Appropriate Utilization
Unique RHP Outcome Identification Number: 137921608.3.2
Performing Provider & TPI: Community Healthcore 137921608

Rationale: The critical performance measure for rate of engagement will be important to determine clinical effectiveness of the program, adjustments that need to be made, and if there are lost opportunities to help the patient. Local emergency departments (ED) expend disproportionate resources toward psychiatric admissions that are non-medical in nature. This is a burden that all ED's in the region experience. Ensuring patients are seen at the right place at the right time is critical to increased efficiency and decreased costs.

Outcome Narrative: please address why process milestones and outcome measure were selected. Process milestones chosen include stakeholder engagement that will assist in the development of a plan for sustainability should the projects funding be reduced or eliminated. Similarly, community inclusion for buy-in to the project is important for success in the shift needed in culture of individuals going to the Emergency Department versus the Regional Crisis Response Center (RCRC). A marketing campaign in the community to include the RCRC, local hospitals, local law enforcement and county officials is necessary as a part of the culture change. Capturing the accuracy of the projected admission to actual admissions is important if there are adjustments in the projects. Employing a Plan Do Stud Act (PDSA) cycle will assist in the rapid change processes that will be needed to make the program viable in the midst of change.
Outcome improvement targets were chosen to specifically target individuals that are being seen in the ED with conditions that are not primarily medical in natures. Specifically behavioral health and substance use disorders that are seen in the ED require significant more resources than are necessary for non-medical conditions.

Outcome Measure Valuation: Valuation of the project included cost avoidance with reduced Emergency Department costs for extended stay of individuals that are non-medical in nature, but require a "safe environment". Similarly, an expected reduction of admissions into the hospital through the ED is expected with an increased availability for the hospitals to treat non-psychiatric patients thereby generating revenue by admissions that are in the right place at the right time. An expected reduction of admissions to the state hospital will be achieved through wrap around services and keeping individuals in the community appropriately and preventing loss of work productivity for long periods of absence from the community. Transportation costs for the counties will be reduced and will free law enforcement to return to work "on the streets" for safety issues.

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.2**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-9.2**	*[Outcome Measure (Improvement Target) Title]* **ED appropriate utilization (Standalone measure)**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization. Project Options	~~137921608.1.13~~ 137921608.1.2		
Starting Point/Baseline: 934/yr			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 ~~[*RHP PP Process Milestone* – P-Y]: [*Insert specific language for selected process milestone if applicable*]~~ P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source**: Attendance lists & Written Implementation Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $40,694 **Process Milestone 2** P-2: Establish baseline rates: Data Source: 1.Establish base line ED admissions, 2. Establish baseline LOS in ED for psych admissions	**Process Milestone 3** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: 1. ED admissions, 2. LOS in ED for psych admission Process Milestone 3 Estimated Incentive Payment: $254,797 **Outcome Improvement Target 1** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse Data Source: 1. ED admissions, 2. LOS in ED for psych admission Outcome Improvement Target 1 Estimated Incentive Payment*:* $254,797	**Outcome Improvement Target 2** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse by 10% over baseline Data Source: 1. ED admissions, 2. LOS in ED for psych admission Outcome Improvement Target 1 Estimated Incentive Payment*:* $461,667	**Outcome Improvement Target 3** IT-9.2: Reduce Emergency Department visits for target conditions; Behavioral Health/Substance Abuse 15% over baseline Data Source: 1. ED admissions, 2. LOS in ED for psych admission Outcome Improvement Target 1 Estimated Incentive Payment*:* $909,499

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.2**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-9.2**	*[Outcome Measure (Improvement Target) Title]* **ED appropriate utilization (Standalone measure)**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization. Project Options	~~137921608.1.13~~ 137921608.1.2		
Starting Point/Baseline: 934/yr			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 2 Estimated Incentive Payment: $40,694			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $81,388	Year 3 Estimated Outcome Amount: $509,594	Year 4 Estimated Outcome Amount: $461,667	Year 5 Estimated Outcome Amount: $909,499
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,962,147			

Outcome Measure (Improvement Target): IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate
Unique RHP Outcome Identification Number: 137921608.3.3
Performing Provider & TPI: Community Healthcore 137921608

Rationale: Readmission rates for shorter intervals are likely related to clinical care and/or discharge planning. Patient age and the presence of certain major mental health or substance abuse problems as a co-morbid condition in the initial admission is likely to increase the probability of a readmission The critical performance measure for rate of readmissions will be important to determine clinical effectiveness of the program and if adjustments need to be made. Disproportionate costs associated with re-admissions are a burden on the patient, the emergency department that often sees the readmit initially due to emergency status, and to the community.

The location of the project is in the poorest area of Tyler/Smith County. Collaboration with UTHSC-Tyler indicates that a significant number of individuals in north Tyler seek their primary care and specialty care through the emergency department (ED) of UTHSC-Tyler. By establishing a specialty care clinic for ambulatory detoxification that will afford individuals the opportunity for treatment that has typically been unable to achieve in-patient treatment, use of the ED for non-emergency care is expected to decrease. The establishment of a baseline in DY3 with expected gains in Dy4 and DY5 costs to local EDs should be alleviated.

Outcome Measure Valuation: Given the increasing pressure to control health care costs and improve quality Valuation of the project included cost avoidance with reduced Emergency Department costs for readmissions occurring through the most likely avenue patients will take when in distress. These extended stay of individuals that are non-medical in nature, but require a “safe environment” drive costs and the value of ensuring patients are seen at the right place at the right time is critical to increased efficiency and decreased costs. Similarly, an expected reduction of admissions into the hospital through the ED is expected with an increased availability for the hospitals to treat non-psychiatric patients thereby generating revenue by more appropriate urgent/emergent admissions.

[~~Unique Category 3 outcome measure identifier(s], e.g. [TPI].3.1)~~ 137921608.3.3	~~[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT X.X]~~ 3.IT-3.8	~~[Outcome Measure (Improvement Target) Title]~~ Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure)*	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 1.9.2 Improve access to specialty care	~~137921608.1.9~~ 137921608.1.3		
Starting Point/Baseline: 250/yr			
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 ~~[RHP PP Process Milestone – P-Y]: [Insert specific language for selected process milestone if applicable]~~ P-1: Project planning - engage stakeholders, identify current capacity and needed resources via specialty gap assessment. Data Source: Attendance lists stakeholder needs assessment Process Milestone 1 Estimated Incentive Payment (maximum amount): $17,300 **Process Milestone 2** P-2: Establish baseline rates: Data Source: 1.Establish base line ambulatory detoxification admissions, 2. Establish baseline completion of detox program vs AMA discharges Process Milestone 2 Estimated Incentive Payment: $17,299	**Process Milestone 3** P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: 1. Ambulatory detoxification admissions, 2. completion of detox program Process Milestone 3 Estimated Incentive Payment: $34,138 Outcome Improvement Milestones Outcome Improvement Target 1 ~~IT-9.2~~ IT-3.8: Increase ambulatory detoxification admissions for target population; Behavioral Health/Substance Abuse Data Source: 1. ambulatory detoxification admissions, 2. Reduce AMA discharges over established baseline Outcome Improvement Target 1 Estimated Incentive Payment: $34,138	Outcome Improvement Milestones Outcome Improvement Target ~~2 IT-9.2~~ IT-3.8: Increase ambulatory detoxification admissions for target population; Behavioral Health/Substance Abuse Data Source: 1. ambulatory detoxification admissions, 2. Reduce AMA discharges over established baseline Outcome Improvement Target 2 Estimated Incentive Payment: $73,512	Outcome Improvement Milestones Outcome Improvement Target ~~3 IT-9.2~~ IT-3.8: Increase ambulatory detoxification admissions for target population; Behavioral Health/Substance Abuse Data Source: 1. ambulatory detoxification admissions, 2. Reduce AMA discharges over established baseline Outcome Improvement Target 3 Estimated Incentive Payment: $149,061

[~~Unique Category 3 outcome measure identifier(s], e.g. [TPI].3.1)~~ 137921608.3.3	~~[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]~~ 3.IT-3.8	~~[Outcome Measure (Improvement Target) Title]~~ Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure)*	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 1.9.2 Improve access to specialty care	~~137921608.1.9~~ 137921608.1.3		
Starting Point/Baseline: 250/yr			
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $34,599	Year 3 Estimated Outcome Amount: $68,276	Year 4 Estimated Outcome Amount: $73,512	Year 5 Estimated Outcome Amount: $149,061
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $325,448			

Outcome Measure (Improvement Target):
IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)228 (Standalone measure)
~~IT-1.11 Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061 (Standalone measure)~~
Unique RHP Outcome Identification Number: 137921608.3.4
~~137921608.3.5~~
Performing Provider & TPI: Community Healthcore 137921608

Rationale:
Local physicians attempting to treat mental illness and emergency departments (ED) expending disproportionate resources toward psychiatric admissions that are non-medical in nature and for individuals seeking primary care through the emergency department result in poor and expensive care. This is a burden that all ED's in the region experience. Ensuring patients are seen at the right place at the right time is critical to increased efficiency and decreased costs. Providing primary care and behavioral care for individuals seeking primary versus emergent or urgent care for mental illness, hypertension and comprehensive diabetic care in co-occurring patients will improve health outcomes, healthcare in general and reduced costs.

Outcome Measure Valuation:

Valuation of the project included cost avoidance with a reduction in admissions to the hospital through the emergency department (the most expensive care for the hospital) for both non-emergency primary care and psychiatric related illnesses that do not require in-patient psychiatric care would result in costs reductions for hospitals and engage individuals in a medical home by treating “the right care at the right time in the right setting.” An expected reduction of admissions to the state hospital will be achieved through wrap around services and keeping individuals in the community appropriately and preventing loss of work productivity for long periods of absence from the community. It would bring primary care to individuals with psychiatric illnesses and provide better care and offer opportunities for both primary and behavioral symptoms to be detected early before delayed and more expensive care is needed.

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.4**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-1.7**	*[Outcome Measure (Improvement Target) Title]* **OD-1- Primary Care and Chronic Disease Management**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 2.15 Integrate Primary and Behavioral Health Care Services	**137921608.2.1**		
Starting Point/Baseline: 250/yr beginning year DY3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-Y]: [*Insert specific language for selected process milestone if applicable*] P-1: Project planning - Conduct needs assessment, Identify Clinic sites Data Source: Attendance lists & Written Implementation Plan Process Milestone 1 Estimated Incentive Payment*:* $1,666 **Process Milestone 2** P-2: Establish baseline rates: Data Source: 1.Establish base line BP of patients in integrated program, 2. Establish baseline of Diabetes care patients in integrated program Process Milestone 2 Estimated Incentive Payment: $1,667	**Outcome Improvement Target 1** IT-1.7 Reduce the number of individuals with uncontrolled high blood pressure by 10% over baseline. (275 patients) Data Source: 1. EHR, 2 Registry. Outcome Improvement Target 1 Estimated Incentive Payment*:* ~~$2,500~~ $5,000	**Outcome Improvement Target 1** IT-1.7 Reduce the number of individuals with uncontrolled high blood pressure by 15% over baseline. (288 patients) Data Source: 1. EHR, 2 Registry. Outcome Improvement Target 1 Estimated Incentive Payment*:* ~~$2,500~~ $5,000	**Outcome Improvement Target 1** IT-1.7 Reduce the number of individuals with uncontrolled high blood pressure by 20% over baseline. (300 patients) Data Source: 1. EHR, 2 Registry. Outcome Improvement Target 1 Estimated Incentive Payment*:* ~~$2,500~~ $5,000

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.4**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3.IT-1.7**	*[Outcome Measure (Improvement Target) Title]* **OD-1- Primary Care and Chronic Disease Management**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 2.15 Integrate Primary and Behavioral Health Care Services	**137921608.2.1**		
Starting Point/Baseline: 250/yr beginning year DY3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: 1.Admission base line BP of patients in integrated program, 2. Admission baseline of Diabetes care patients in integrated program Process Milestone 3 Estimated Incentive Payment: $1,667			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $5,000	Year 3 Estimated Outcome Amount: $5,000	Year 4 Estimated Outcome Amount: $5,000	Year 5 Estimated Outcome Amount: $5,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $20,000			

Outcome Measure (Improvement Target):
IT-1.11 Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061 (Standalone measure)
Unique RHP Outcome Identification Number: 137921608.3.5
Performing Provider & TPI: Community Healthcore 137921608

Rationale:
Local physicians attempting to treat mental illness and emergency departments (ED) expending disproportionate resources toward psychiatric admissions that are non-medical in nature and for individuals seeking primary care through the emergency department result in poor and expensive care. This is a burden that all ED's in the region experience. Ensuring patients are seen at the right place at the right time is critical to increased efficiency and decreased costs. Providing primary care and behavioral care for individuals seeking primary versus emergent or urgent care for mental illness, hypertension and comprehensive diabetic care in co-occurring patients will improve health outcomes, healthcare in general and reduced costs.

Conducting a needs assessment of individuals in behavioral care in need of primary care options will **improved care** by increasing covered lives in primary care and offering rural residents comprehensive mental health treatment in their own community where they have natural supports and are more likely to remain engaged. High blood pressure (hypertension) is an important risk factor for the development and worsening of many complications of diabetes, including diabetic eye disease and kidney disease. Most people with diabetes develop high blood pressure during their life. This project seeks to **improve health outcomes** through consistent continuity care and integrated mental and physical health care guided by a collaborative intake and patient registry system to enhance continuity, support medication reconciliation and avoid duplication of effort and track care and treatment across providers to quantify impact based upon services received, when received, how received. **Lower costs** as the number of psychiatric patients seeking treatment from an ER is reduced and law enforcement has more time for public safety when deputy sheriffs do not make daily trips from remote areas to the state hospital.

Outcome Measure Valuation:
Valuation of the project included cost avoidance with a reduction in admissions to the hospital through the emergency department (the most expensive care for the hospital) for both non-emergency primary care and psychiatric related illnesses that do not require in-patient psychiatric care would result in costs reductions for hospitals and engage individuals in a medical home by treating "the right care at the right time in the right setting." An expected reduction of admissions to the state hospital will be achieved through wrap around services and keeping individuals in the community appropriately and preventing loss of work productivity for long periods of absence from the community. It would bring primary care to individuals with psychiatric illnesses and provide better care and offer opportunities for both primary and behavioral symptoms to be detected early before delayed and more expensive care is needed.

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.5**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3. IT-1.11**	*[Outcome Measure (Improvement Target) Title]* **OD-1- Primary Care and Chronic Disease Management**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 2.15 Integrate Primary and Behavioral Health Care Services	**137921608.2.2**		
Starting Point/Baseline: 250/yr beginning year DY3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-Y]: [*Insert specific language for selected process milestone if applicable*] P-1: Project planning - Conduct needs assessment, Identify Clinic sites Data Source: Attendance lists & Written Implementation Plan Process Milestone 1 Estimated Incentive Payment*:* $1,666 **Process Milestone 2** P-2: Establish baseline rates: Data Source: 1.Establish base line BP of patients in integrated program, 2. Establish baseline of Diabetes care patients in integrated program Process Milestone 2 Estimated Incentive Payment: $1,667	**Outcome Improvement Target 1** IT-1.11 Reduce the number of individuals with uncontrolled Diabetes care: *BP control (<140/80mm Hg) – NQF* 0061 *(Standalone measure)* by 10% over baseline. (275 patients) Data Source: 1. EHR, 2. Registry, Claims, 3. Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment*:* ~~$2,500~~ $5,000	**Outcome Improvement Target 1** IT-1.11 Reduce the number of individuals with uncontrolled Diabetes care: *BP control (<140/80mm Hg) – NQF* 0061 *(Standalone measure)* by 15% over baseline. (288 patients) Data Source: 1. EHR, 2. Registry, Claims, 3. Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment*:* ~~$2,500~~ $5,000	**Outcome Improvement Target 1** IT-1.11 Reduce the number of individuals with uncontrolled Diabetes care: *BP control (<140/80mm Hg) – NQF* 0061 *(Standalone measure)* by 20% over baseline. (300 patients) Data Source: 1. EHR, 2. Registry, Claims, 3. Administrative clinical data Outcome Improvement Target 1 Estimated Incentive Payment*:* ~~$2,500~~ $5,000

[Unique Category 3 outcome measure identifier(s), e.g. [TPI].3.1} **137921608.3.5**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **3. IT-1.11**	*[Outcome Measure (Improvement Target) Title]* **OD-1- Primary Care and Chronic Disease Management**	
Community Healthcore			137921608
Related Category 1 or 2 Projects: 2.15 Integrate Primary and Behavioral Health Care Services	**137921608.2.2**		
Starting Point/Baseline: 250/yr beginning year DY3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: 1.Admission base line BP of patients in integrated program, 2. Admission baseline of Diabetes care patients in integrated program Process Milestone 3 Estimated Incentive Payment: $1,667			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $5,000	Year 3 Estimated Outcome Amount: $5,000	Year 4 Estimated Outcome Amount: $5,000	Year 5 Estimated Outcome Amount: $5,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $20,000			

Outcome Measure (Improvement Target): IT-10.1 Quality of Life
Unique RHP Outcome Identification Number: 138360606.3.1
Performing Provider & TPI: Northeast Texas Public Health District 138360606

The Category 3 Outcome Measure to be used in this project is IT-10.1 Quality of Life. This project number is 138360606.3.1. This outcome measure will be used to demonstrate improvement in quality of life (QOL) scores, as measured by an evidence-based and validated assessment tool, for our target population. The AQoL-8D assessment tool will be used for both adults and adolescents. Baseline data for each client will be taken through an initial quality of life assessment. The AQoL-8D for adults and the AQoL-8D for adolescents. The AQoL scores will be computed using an algorithm in SPSS software that was developed by the Centre for Health Economics at Monash University in Australia. New surveys will be completed every 6 months..

The outcome measure selected for the Center for Healthy Living project is category 3 measure IT-10.1 Quality of Life. Through the implementation of evidenced-based projects in an underserved community, the following outlined category 2.6.2 project, the five-year outcome is to increase AQoL-8D scores in 20% of the program participants.

- 2.6.2 – Establish self-management programs and wellness using evidence-based designs.

By empowering the community through health education messaging and self- management programs, the intended audience would be better equipped to include healthy activities into their daily life and impact their overall quality of life.

Baseline Data collection, needs assessment and priority planning will occur in DY 2 to identify current AQoL results and throughout the five-year project participants will complete the Quality of Life survey AQoL – 8D every six months of participation at the Center.

The Community Needs Assessment, included in the RHP for Region 1 as identification numbers CN.3 and CN.4, outlines the following highlighted health disparities which are the basis of the development of the Center for Healthy Living Project.

- Blood Pressure: “The Department of State Health Services estimates that 43.1% of the African American Population in East Texas has high blood pressure compared to 33.9% of African Americans in Texas. DSHS also estimates that 32.4% of the White/Caucasian population in East Texas has high blood pressure compared to 28.2% of the White/Caucasian population in Texas.”
- Cholesterol: “East Texas has significantly lower rates of cholesterol screening than statewide averages.”

The targeted population within the City of Tyler and the St. Louis neighborhood will be individuals who initially report lack of access to healthy living resources. By conducting a direct participant survey for data collection purposes, we will be able to quantify the actual increase over the baseline data collected in Dy2.

Additionally, tracking of participation in programs, screening improvements, direct health outcome improvements related directly to blood pressure, cholesterol, tobacco usage, diet and physical activity will impact the measurements of quality of life.

Other projects within RHP Region 1 focus mostly on clinical care, treatment and specialty care, while this project focuses solely on prevention and health education. However, since we have a strong partnership with all hospitals and healthcare providers in our area, we will have supplemental contributions to our project through possible client referrals and recommendations.

Project Valuation: The estimated local funding to support the project is approximately $66,000. Based on the estimated local funding available and the amount of incentive payment assigned to the milestones in category 2, the following has been established to value the category 3 outcomes. The expenses related to data collection are addressed as milestones in category 2, leaving the valuation for category 3 data collection to be minimal to address the reporting of the data. The valuation for DY3 and DY4 take into account the expense of SRSS analysis software and the expenses related to administering and analyzing the AQoL survey. The significant increase in DY5 valuation in this category is directly related to the decrease in category 2, with the rationale being that DY5 will have a predominant focus on the outcomes of the project and most of the expenses NET Health incurs will be directly related to outcome measures.

138360606.3.1	*3.IT-10.1*	*Quality of Life*	
NORTHEAST TEXAS PUBLIC HEALTH DISTRICT			**1383606-06**
Related Category 1 or 2 Projects:	**138360606.2.1 – 2.6.2**		
Starting Point/Baseline:	*Currently No Baseline – New Project*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources Data Source: Community Health Needs Assessment Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 3,500 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Community Health Needs Assessment Process Milestone 2 Estimated Incentive Payment: $ 3,500 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 3 [P-4]: Conduct Plan do Study Act (PDSA) cycles to improve data collection and intervention activities** Data Source: **Performing provider quality assurance plan, implementation strategy and plan** Process Milestone 3 Estimated Incentive Payment: $16,500 **Outcome Improvement Target 1** [IT-10.1]: Quality of Life Improvement Target: Increase AQoL-8D scores in 5% of the programs participants Data Source: AQoL Surveys - SRSS Data Analysis Outcome Improvement Target	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life Improvement Target: Increase AQoL-8D scores in 10% of the programs participants Data Source: AQoL Surveys - SRSS Data Analysis Outcome Improvement Target 2 Estimated Incentive Payment*:* $33,000	**Outcome Improvement Target 3** [IT-10.1]:Quality of Life Improvement Target: Increase AQoL-8D scores in 20% of the programs participants Data Source: AQoL Surveys - SRSS Data Analysis Outcome Improvement Target 3 Estimated Incentive Payment*:* $55,000

138360606.3.1	*3.IT-10.1*	*Quality of Life*	
NORTHEAST TEXAS PUBLIC HEALTH DISTRICT			**1383606-06**
Related Category 1 or 2 Projects:	**138360606.2.1 – 2.6.2**		
Starting Point/Baseline:	*Currently No Baseline – New Project*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	1 Estimated Incentive Payment*:* $16,500		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 7,000	Year 3 Estimated Outcome Amount: $33,000	Year 4 Estimated Outcome Amount: $33,000	Year 5 Estimated Outcome Amount: $55,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $128,000			

Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 138365512.3.1
Performing Provider & TPI: Andrews Center 138365512

Outcome Measure Description: The crisis intervention center (138365512.1.1) will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients. The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in ED visit reduction. Andrews Center plans to decrease ED visits for patients receiving interventions through crisis stabilization and primary/behavioral health integration services by 2.5% and 5% in demonstration years 4 and 5, respectively.

According to the Texas Department of State Health Services, nearly 50% of 2008 hospitalizations in Texas had a secondary diagnosis of a mental health condition. A vast majority of these hospitalization initiated in the ED due to the shortage of crisis intervention services.

Rationale: Inappropriate ED utilization is harmful to recovery from behavioral health disorders. Patients in crisis currently have very few options other than local hospital emergency rooms in which to receive care. This is especially true after business hours when ED's are truly the only option. Once these patients arrive at the emergency room patients often find that ED staff is not trained in to deal with mental health, substance abuse and suicide prevention issues. The ED provides no immediate psychiatric intervention during crisis assessment and leads to long psychiatric holds while incurring higher costs than specialized mental health care. After lengthy, costly, and ineffective ED stays, follow up appointments to see a psychiatrist are sometimes weeks and months away. Furthermore, law enforcement is often required to stay with patients during their emergency room stay—adding to the costly assortment of resources required to care for behavioral health patients in the ED. Moreover, emergency room discharge planning is often impeded by no mental health deputy on site for situations that warrant law enforcement intervention, and the lack of designated staff that can physically accompany the patient from crisis episode to referral resources and appointments.

Outcome Measure Valuation: Studies have demonstrated the adverse effects of emergency department boarding of behavioral health patients. Excessive resource utilization, throughput, and financial impact of psychiatric patients awaiting inpatient placement places a burden on hospital EDs and negatively impacts appropriate care for the behavioral health population. Furthermore, emergency department length of stay is significantly longer for psychiatric admissions when compared to non-psychiatric admissions. The financial impact of psychiatric boarding accounts for a direct loss of $1,198 compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department $2,264 per patient. Lastly, psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric

patients, preventing 2.2 bed turnovers (additional patients) per psychiatric patient—decreasing financial revenue for the ED and costing the healthcare system more reimbursement dollars. In addition to excessive ED cost, patients also incur costs for being admitted to an inpatient facility and/or jail. These costs, along with Sheriff's Deputy oversight in the ED, often build on the initial ED cost since the ED is the typical initial access point.

The following table shows the potential ED and inpatient savings of crisis response intervention. These savings exceed the cost the implementation and the overall DSRIP funding for both projects.

Estimated Savings per Crisis Response Center Location		
1,296 Pts Served @ **15%** reduction of services		194
ED Cost per Psych Patient[1]	$	2,264
ED Savings	**$**	**440,122**
Psych Inp Admit from ED @ 35.1%[1]		68
Inpatient Psych ALOS		10
Cost per Inpatient Psych day[2]	$	685
Inpatient Psych Savings	**$**	**467,412**
Psych ED Patients Jailed @ 5%		10
Days in Jail per Offender[3]		260
Cost of Psych Inmate per Day[3]	$	137
Jail Savings	**$**	**346,226**
Sheriff's Deputies per 194 Patients		0.75
Sheriff's Deputy per Year	$	53,500
Deputy Savings	**$**	**40,042**
Total Estimated Savings	**$**	**1,293,802**

1) *Emergency Medicine International*, 2012
2) CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011
3) National Alliance on Mental Illness

138365512.3.1	***3.IT-9.2***	**ED Appropriate Utilization**	
Andrews Center			***138365512***
Related Category 1 or 2 Projects:	***138365512.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of ED visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions Numerator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions that had an ED visit Denominator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions **Metric:** Documentation of baseline rate of ED visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records	**Outcome Improvement Target 1: IT-9.2** ED Appropriate Utilization: Reduce Emergency Department visits for behavioral health/substance abuse patients Numerator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions that had an ED visit Denominator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions **Improvement Target:** 2.5% decrease in Emergency Department visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions, calculated as: (new # -baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records	**Outcome Improvement Target 2: IT-9.2** ED Appropriate Utilization: Reduce Emergency Department visits for behavioral health/substance abuse patients Numerator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions that had an ED visit Denominator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions **Improvement Target:** 5% decrease in Emergency Department visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions, calculated as: (new # -baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records
Process Milestone 1 Estimated Incentive Payment: $ 41,492	**Process Milestone 2 Estimated Incentive Payment:** $ 96,195	**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 102,904	**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 223,705
Year 2 Estimated Total DSRIP Funding (add each milestone): $41,492	Year 3 Estimated Total DSRIP Funding: $96,195	Year 4 Estimated Total DSRIP Funding: $102,904	Year 5 Estimated Total DSRIP Funding: $223,705
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$464,295***			

Outcome Measure (Improvement Target): IT-9.1 – Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.
Unique RHP Outcome Identification Number: 138365512.3.2
Performing Provider & TPI: Andrews Center 138365512

Outcome Measure Description: Implementing our evidence-based intervention to keep behavioral health patients out of the justice system will decrease recidivism rates and meet the following community needs: insufficient access to behavioral care services (CN.2), high costs due to potentially preventable hospitalizations (CN.4), and inappropriate emergency room utilization (CN.5).

The jail diversion project (138365512.2.1) will decrease mental health admissions and readmissions to criminal justice settings such as jails or prisons (*3.IT-9.1)*. The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement of admissions and readmissions to criminal justice settings. Andrews Center plans to decrease mental health admissions and readmissions to criminal justice settings by 5% and 10% in demonstration years 4 and 5, respectively.

Rationale: Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

Currently there is a lack of community resources for those with behavioral health problems involved in the criminal justice system. These include a lack of qualified treatment providers and the encroachment of forensic beds upon civil beds. Along with the stigmatism of behavioral health disorders, a large number of people with mental illness have a lack of housing, insurance, and employment. Research supports that approximately 70% of persons releasing from prison or jail who have a serious mental illness recidivate within 3 years when they receive no treatment. The Bureau of Justice Statistics estimates that the overall average jail sentence is 6 months, while inmates with a serious and persistent mental illness typically serve 80 days longer.

This project will reduce inappropriate use of the jail as a treatment facility while keeping offenders with SPMI from decompensating and requiring long-term forensic commitments, often longer than 120 days. Forensic commitments are rapidly encroaching on available crisis beds. If crisis beds are not available and community based treatment is inaccessible, the last resort is the criminal justice system. According to the Center for Mental Health Service's National GAINS Center, the Sequential Intercept Model has been used as the gold standard for

communities to help organize mental health service system transformation–meeting the needs of people with mental illness involved with the criminal justice system. The model helps to assess where diversion activities may be developed, how institutions can better meet treatment needs, and when to begin activities to facilitate re-entry. Research supports that delivery of comprehensive behavioral health in the community setting, as opposed to the institutional setting, is more effective for long- term community tenure. Implementing this model of jail diversion is proven to reduce the revolving door from homelessness to jail to hospital to prison. As noted in the Region 1 community needs assessment (CN.2), there is a shortage of behavioral health providers. Our jail diversion plan will strive to fill the shortage gap of behavioral health services.

Outcome Measure Valuation: According to the National Alliance on Mental Illness, Community Behavioral Health is estimated to cost on average $12 per day, whereas incarceration costs approximately $137 per day for those with a mental illness. Hospitalization costs begin around $400 per day, with usage of the emergency room costing around $1,265 per encounter. Inmates with a serious and persistent mental illness (SPMI) typically serve 80 days longer than those without, according to NAMI. Bureau of Justice Statistics lists that the average jail sentence overall is just over 6 months; so inmates with a SPMI on average serve almost 9 months in jail. If we serve 75 offenders with a 17.6% recidivism rate, then we have a valuation of $2.2 Million for prevented inmate costs.
The cost savings shown below exceed the cost the implementation and the overall DSRIP funding for jail diversion and its outcome measure:

Estimated Annual Savings Sequential Intercept Model	
Behavioral Health Offenders Served	75
Recidivism Rate	17.6%
Offenders Prevented Jail Re-entry	**62**
Days in Jail per Offender	260
Jail Re-entry Days Prevented	**16,068**
Cost of Inmate w/SMI per Day	$ 137
Estimated Annual Savings	**$2,201,316**

138365512.3.2	***3.IT-9.1***	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons**	
Andrews Center			***138365512***
Related Category 1 or 2 Projects:	***138365512.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of mental health admissions and readmissions to criminal justice settings Numerator: The number of individuals receiving project interventions who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period. Denominator: The number of individuals receiving project interventions. **Metric:** Documentation of baseline rate of mental health admissions and readmissions to criminal justice settings **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records	**Outcome Improvement Target 1: IT-9.1** Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Numerator: The number of individuals receiving project interventions who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period. Denominator: The number of individuals receiving project interventions. **Improvement Target:** 5% decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons, calculated as: (new # - baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records	**Outcome Improvement Target 2: IT-9.1** Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Numerator: The number of individuals receiving project interventions who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period. Denominator: The number of individuals receiving project interventions. **Improvement Target:** 10% decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons, calculated as: (new # - baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records
Process Milestone 1 Estimated Incentive Payment: $ 34,577	**Process Milestone 2 Estimated Incentive Payment:** $ 80,162	**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 85,753	**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 186,421
Year 2 Estimated Total DSRIP Funding (add each milestone): $34,577	Year 3 Estimated Total DSRIP Funding: $80,162	Year 4 Estimated Total DSRIP Funding: $85,753	Year 5 Estimated Total DSRIP Funding: $186,421
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$386,913***			

Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 138365512.3.3
Performing Provider & TPI: Andrews Center 138365512

Outcome Measure Description: The primary and behavioral health integration project (138365512.2.2) will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients (IT-9.2). Giving behavioral health patients access to primary care—and vice versa—will decrease the need for services in the ED. The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in ED visit reduction. Andrews Center plans to decrease ED visits for patients receiving interventions through primary and behavioral care integration by 2.5% and 5% in demonstration years 4 and 5, respectively.

Rationale: Inappropriate ED utilization is harmful to recovery from behavioral health disorders. Patients in crisis currently have very few options other than local hospital emergency rooms in which to receive care. This is especially true after business hours when ED's are truly the only option. Once these patients arrive at the emergency room patients often find that ED staff is not trained in to deal with mental health, substance abuse and suicide prevention issues. The ED provides no immediate psychiatric intervention during crisis assessment and leads to long psychiatric holds while incurring higher costs than specialized mental health care. After lengthy, costly, and ineffective ED stays, follow up appointments to see a psychiatrist are sometimes weeks and months away. Furthermore, law enforcement is often required to stay with patients during their emergency room stay—adding to the costly assortment of resources required to care for behavioral health patients in the ED. Moreover, emergency room discharge planning is often impeded by no mental health deputy on site for situations that warrant law enforcement intervention, and the lack of designated staff that can physically accompany the patient from crisis episode to referral resources and appointments.

Outcome Measure Valuation: Studies have demonstrated the adverse effects of emergency department boarding of behavioral health patients. Excessive resource utilization, throughput, and financial impact of psychiatric patients awaiting inpatient placement places a burden on hospital EDs and negatively impacts appropriate care for the behavioral health population. Furthermore, emergency department length of stay is significantly longer for psychiatric admissions when compared to non-psychiatric admissions. The financial impact of psychiatric boarding accounts for a direct loss of $1,198 compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department $2,264 per patient. Lastly, psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers (additional patients) per psychiatric patient—decreasing financial revenue for the ED and costing the healthcare system more reimbursement dollars. In addition to excessive ED cost, patients also incur costs for being admitted to an inpatient facility

and/or jail. These costs, along with Sheriff's Deputy oversight in the ED, often build on the initial ED cost since the ED is the typical initial access point.

The following table shows the potential annual ED and inpatient savings of crisis response intervention. These savings exceed the cost the implementation and the overall DSRIP funding for both projects.

Estimated Annual Savings for Primary/Behavioral Integration		
1,296 Pts Served @ 15% reduction of services		194
ED Cost per Psych Patient[1]	$	2,264
ED Savings	**$**	**440,122**
Psych Inp Admit from ED @ 35.1%[1]		68
Inpatient Psych ALOS		10
Cost per Inpatient Psych day[2]	$	685
Inpatient Psych Savings	**$**	**467,412**
Psych ED Patients Jailed @ 5%		10
Days in Jail per Offender[3]		260
Cost of Psych Inmate per Day[3]	$	137
Jail Savings	**$**	**346,226**
Sheriff's Deputies per 194 Patients		0.75
Sheriff's Deputy per Year	$	53,500
Deputy Savings	**$**	**40,042**
Total Estimated Savings	**$**	**1,293,802**

1) *Emergency Medicine International*, 2012
2) CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011
3) National Alliance on Mental Illness

138365512.3.3	***3.IT-9.2***	**ED Appropriate Utilization**	
Andrews Center			***138365512***
Related Category 1 or 2 Projects:	***138365512.2.2***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of ED visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions Numerator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions that had an ED visit Denominator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions **Metric:** Documentation of baseline rate of ED visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records	**Outcome Improvement Target 1: IT-9.2** ED Appropriate Utilization: Reduce Emergency Department visits for behavioral health/substance abuse patients Numerator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions that had an ED visit Denominator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions **Improvement Target:** 2.5% decrease in Emergency Department visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions, calculated as: (new # -baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records	**Outcome Improvement Target 2: IT-9.2** ED Appropriate Utilization: Reduce Emergency Department visits for behavioral health/substance abuse patients Numerator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions that had an ED visit Denominator: The number of individuals receiving crisis response or primary/ behavioral health integration interventions **Improvement Target:** 5% decrease in Emergency Department visits for behavioral health/substance abuse patients receiving crisis or integrated health interventions, calculated as: (new # -baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records
Process Milestone 1 Estimated Incentive Payment: $ 62,238	**Process Milestone 2 Estimated Incentive Payment:** $ 144,292	**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 154,356	**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 335,557
Year 2 Estimated Total DSRIP Funding (add each milestone): $62,238	Year 3 Estimated Total DSRIP Funding: $144,292	Year 4 Estimated Total DSRIP Funding: $154,356	Year 5 Estimated Total DSRIP Funding: $335,557
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$696,443***			

Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 138365512.3.4
Performing Provider & TPI: Andrews Center 138365512

Outcome Measure Description: Expanded outpatient therapy services (138365512.2.3) will prevent inappropriate ED utilization and effectively reduce emergency department visits for behavioral health/substance abuse patients. The Andrews Center plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in ED visit reduction. Andrews Center plans to decrease ED visits for patients receiving interventions through expanded outpatient therapy services by 2.5% and 5% in demonstration years 4 and 5, respectively.

According to the Texas Department of State Health Services, nearly 50% of 2008 hospitalizations in Texas had a secondary diagnosis of a mental health condition. A vast majority of these hospitalizations initiated in the ED due to the shortage of behavioral health services.

Rationale: Evidence based therapies will be utilized to assist clients in the community to improve stabilization once a crisis episode, hospital stay, or ED visit has occurred. It will assist in helping them to maintain a level of functioning in the community that allows them independence on an outpatient basis rather than inpatient basis. The end result will be improved overall global functioning and a decrease in symptoms.

Research indicates that evidence based therapies are effective tools in preventing psychiatric hospital admissions/re-admissions and recurring ED visits. Adding additional therapists would give us the opportunity to impact the lives of persons with disabilities in a positive way. It could provide the emotional support and coping skills needed to decrease admissions to the hospital. It would improve stabilization and assist in maintaining a high level of functioning on an outpatient basis. Adding additional staff would also enable us to relieve the lengthy waiting list for therapy services.

Inappropriate ED utilization is harmful to recovery from behavioral health disorders. Patients needing ongoing behavioral health interventions currently have very few options other than local hospital emergency rooms in which to receive care. Once these patients arrive at the emergency room patients often find that ED staff is not trained in to deal with mental health, substance abuse, and suicide prevention issues. The ED provides no immediate psychiatric intervention during crisis assessment and leads to long psychiatric holds while incurring higher costs than specialized mental health care. Furthermore, law enforcement is often required to stay with patients during their emergency room stay—adding to the costly assortment of resources required to care for behavioral health patients in the ED.

Outcome Measure Valuation: The Andrews Center cost per inpatient psychiatric bed per day is approximately $375, compared to one therapy session at $120. At 5 sessions per client, we

project that 2 additional therapists will be able to provide 2,250 sessions for 450 clients. Providing therapy for 450 clients rather than inpatient utilization will save approximately $1.4 Million per year in future institutionalization costs.

Accordingly, Andrews Center's average DSRIP funding request of approximately $275,000 per year (including Category 2 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Annual Savings Expansion of Therapy Capacity		
New population served		450
Sessions per Year	@ 5 per client	2,250
Therapy Cost per Session		$ 120
Therapy Cost per Year		**270,000**
New population served		450
Inpatient Bed Utilization per Year	ALOS @ 10 days	10
Inpatient Bed Cost per day		$ 375
Inpatient Bed Cost per Year		**$ 1,687,500**
Estimated Annual Savings		**$ 1,417,500**

138365512.3.4	***3.IT-9.2***	**ED Appropriate Utilization**	
Andrews Center			***138365512***
Related Category 1 or 2 Projects:	***138365512.2.3***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $ 11,216	**Process Milestone 2: P-2** Establish baseline rate of ED visits for behavioral health/substance abuse patients receiving outpatient therapy interventions. Numerator: The number of individuals receiving outpatient therapy interventions that had an ED visit Denominator: The number of individuals receiving outpatient therapy interventions **Metric:** Documentation of baseline rate of ED visits for behavioral health/substance abuse patients receiving outpatient therapy interventions **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records **Process Milestone 2 Estimated Incentive Payment:** $ 26,600	**Outcome Improvement Target 1: IT-9.2** ED Appropriate Utilization: Reduce Emergency Department visits for behavioral health/substance abuse patients Numerator: The number of individuals receiving outpatient therapy interventions that had an ED visit Denominator: The number of individuals receiving outpatient therapy interventions **Improvement Target:** 2.5% decrease in Emergency Department visits for behavioral health/substance abuse patients receiving outpatient therapy interventions, calculated as: (new # -baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 28,990	**Outcome Improvement Target 2: IT-9.2** ED Appropriate Utilization: Reduce Emergency Department visits for behavioral health/substance abuse patients Numerator: The number of individuals receiving outpatient therapy interventions that had an ED visit Denominator: The number of individuals receiving outpatient therapy interventions **Improvement Target:** 5% decrease in Emergency Department visits for behavioral health/substance abuse patients receiving outpatient therapy interventions, calculated as: (new # -baseline) /baseline **Data Source:** Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 63,474
Year 2 Estimated Total DSRIP Funding (add each milestone): $11,216	Year 3 Estimated Total DSRIP Funding: $26,600	Year 4 Estimated Total DSRIP Funding: $28,990	Year 5 Estimated Total DSRIP Funding: $63,474
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$130,280***			

Outcome Measure (Improvement Target): IT-4.4 – Surgical site infections rate.
Unique RHP Outcome Identification Number: 138374715.3.1
Performing Provider & TPI: ETMC Pittsburg 138374715

Outcome Measure Description: ETMC Pittsburg's goal is to reduce the number of surgical site infections (SSI) for general surgery cases. ETMC plans to develop and test data systems to measure surgical site infections (SSI) rates during DY 2. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the surgical site infection (SSI) rate. ETMC plans to decrease the surgical site infection (SSI) rate —for general and orthopedic surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively.

We propose to increase the overall quality of care and improve the health status of our target population—general and orthopedic surgery patients at ETMC Pittsburg. Recruiting a general surgeon and orthopedic surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. With quality improvement oversight, a local general surgeon and orthopedic surgeon will decrease surgical site infection (SSI) rates, which are directly related high costs due to potentially preventable hospitalizations (CN.4).

Rationale: While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity and mortality among hospitalized patients. In one study, among nearly 100,000 HAIs reported in one year, deaths were associated with SSIs in more than 8,000 cases. Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk. A successful surveillance program includes the use of epidemiologically-sound infection definitions and effective surveillance methods, stratification of SSI rates according to risk factors associated with SSI development, and data feedback.

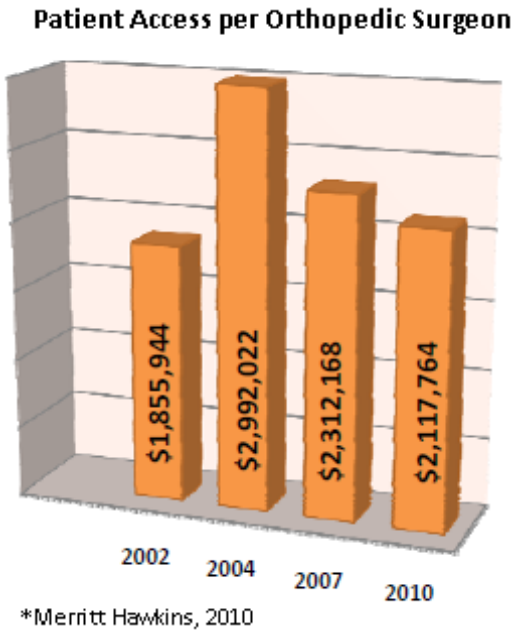
Outcome Measure Valuation: The value of decreasing SSIs is shown in the estimated burden of SSIs in acute care facilities in the United States. There are about 300,000 SSIs per year, costing the United States from $3 billion - $10 billion annually. Each SSI is associated with approximately 7-10 additional postoperative hospital days, and 2%-5% of patients undergoing inpatient surgery develop a SSI. The estimated cost per infection ranges from $11,000 - $35,000; therefore, preventing approximately 46 SSIs between DY 2-5 will produce savings greater than the 4-year total estimated DSRIP funding requested ($1,050,098).

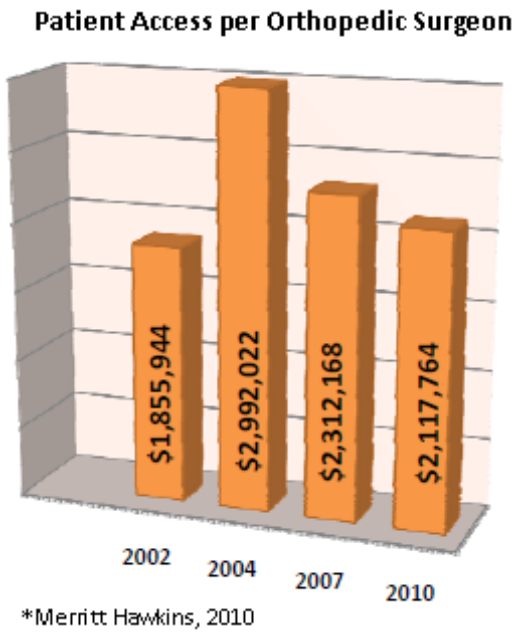
(http://www.vdh.virginia.gov/epidemiology/surveillance/hai/ssi.htm "Surgical Site Infections," Virginia Department of Health. Accessed 10 Oct 2012.)

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a general

surgeon and an orthopedic surgeon on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional general surgeon and orthopedic surgeon.

The charts below value the access expansion of a general surgeon at $2,112,492 per year and an orthopedic surgeon at $2,117,764. Accordingly, ETMC's DSRIP funding request of approximately $1,500,000 per year (including Category 1 and 3) is targeted to be less than the value of access expansion so that the CMS program accrues a net benefit.



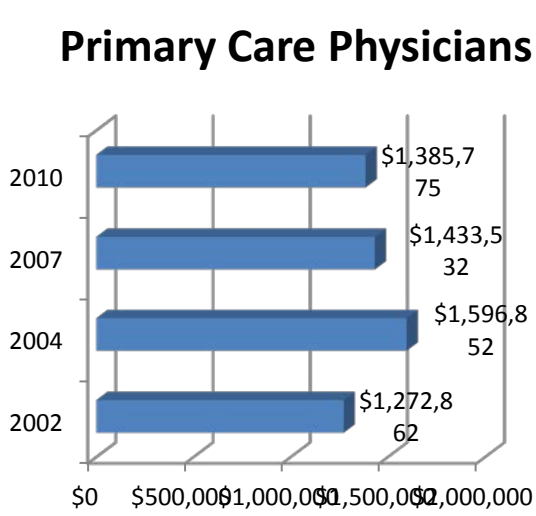


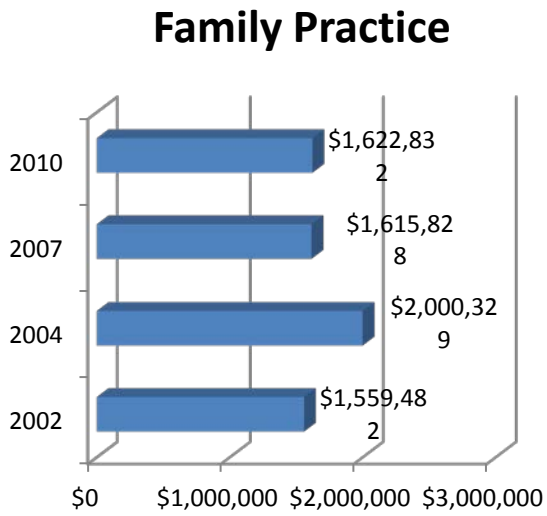
138374715.3.1	***3.IT-4.4***	**Surgical site infections (SSI) rates**	
ETMC Pittsburg			***138374715***
Related Category 1 or 2 Projects:	***138374715.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-3 Develop and test data systems to measure surgical site infection rates **Metric:** Documentation of data capture **Data Source**: EHR, Claims, IQR/NHSN data **Process Milestone 1 Estimated Incentive Payment:** $ 124,023	**Process Milestone 2: P-2** Establish baseline rate of Surgical site infections (SSI) rates Numerator: Number of cases of SSI as designated by IQR criteria Denominator: Total number of cases **Metric:** Documentation of baseline of Surgical site infections (SSI) rates **Data Source:** EHR, Claims, IQR/NHSN data **Process Milestone 2 Estimated Incentive Payment:** $ 143,759	**Outcome Improvement Target 1: IT-4.4** Decrease Surgical site infections (SSI) rates Numerator: Number of cases of SSI as designated by IQR criteria Denominator: Total number of cases **Improvement Target:** 4% decrease in Surgical site infections (SSI) rates, calculated as (new # -baseline) /baseline **Data Source:** EHR, Claims, IQR/NHSN data **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 230,683	**Outcome Improvement Target 2: IT-4.4** Decrease Surgical site infections (SSI) rates Numerator: Number of cases of SSI as designated by IQR criteria Denominator: Total number of cases **Improvement Target:** 8% decrease in Surgical site infections (SSI) rates, calculated as (new # -baseline) /baseline **Data Source:** EHR, Claims, IQR/NHSN data **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 551,633
Year 2 Estimated Total DSRIP Funding: $124,023	Year 3 Estimated Total DSRIP Funding: $143,759	Year 4 Estimated Total DSRIP Funding: $230,683	Year 5 Estimated Total DSRIP Funding: $551,633
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,050,098***			

Outcome Measure (Improvement Target): IT-6.1 – Percent improvement over baseline of patient satisfaction scores.
Unique RHP Project Identification Number: 138913209.3.1
Performing Provider Name: Titus Regional Medical Center ("TRMC") 138913209

Project Description:
The improvement of patient satisfaction scores for the Family Care Center as the result of building a Family Care Center in Mount Pleasant. The project is related to 138913209.1.1. The goal of this project is to provide an improvement in Satisfaction Surveys related to the Family Care Center by the end of the waiver.

Project Valuation:
Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a specialist physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional physician.





The addition of Primary Care physicians in the Family Care Center and additional hours of operation will reduce the unnecessary visits to the emergency room by our residents. The current Level 4 and Level 5 visits to our emergency room are approximately 30% resulting in approximately 6,598 visits which have the potential to be treated in other settings. Assuming a 5% reduction in the Level 4 and Level 5 visits, TRMC projects an estimated cost savings of approximately $250,000 per year.

Savings - Reduction Level IV & V

Total ED Visits (annual)	21,993
Current Avg Level 4 or Below	30%
ED Visits Level 4 or Below	6,598
Reduction of Level 4 or Below	5.0%
Estimated ED Visits Avoided	330
Average ED Visit	$750
Estimated Annual Savings	**$247,416**

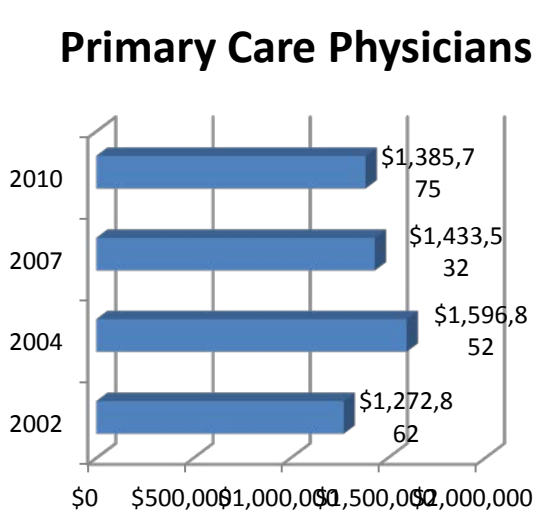
The charts and data above value Primary Care Physicians in Family practice at $1.625 million per year. In addition, the implementation of a Family Care Center will result in at least $250,000 per year in cost of savings. Accordingly, TRMC's average DSRIP funding request of approximately $1,337,408 per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

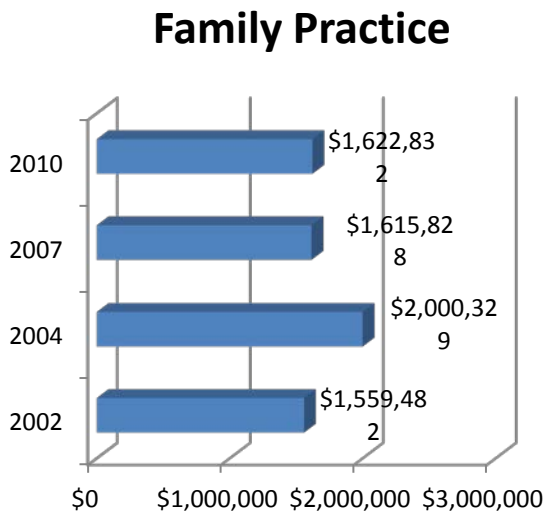
138913209.3.1	3.IT-6.1	Percent improvement over baseline of patient satisfaction scores.	
Titus Regional Medical Center			138913209
Related Category 1 or 2 Projects:	**138913209.1.1**		
Starting Point/Baseline:	*Patient satisfaction surveys: Family Care Center: No baseline*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [*P-1*]: Documentation of project planning approved by the CEO. **Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $74,686**	**Process Milestone 2 P-5**: Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1 [*P-5*]: Documentation of findings and action plans created based on findings. **Process Milestone 2 Estimated Incentive Payment: $86,571**	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores for Family Care Center. Metric 1 [IT-6.1]: Increase of patient satisfaction scores compared to baseline of DY 3. **Outcome Improvement Target 2 Estimated Incentive Payment*:* $138,917**	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores for Family Care Center. Metric 1 [IT-6.1]: Increase patient satisfaction scores compared to baseline of DY 3. **Outcome Improvement Target 4 Estimated Incentive Payment*:* $332,192**
Year 2 Estimated Outcome Amount: $74,686	**Year 3 Estimated Outcome Amount: $86,571**	**Year 4 Estimated Outcome Amount: $138,917**	**Year 5 Estimated Outcome Amount: $332,192**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $632,366			

Outcome Measure (Improvement Target): IT-9.2 – ED appropriate utilization.
Unique RHP Project Identification Number: 138913209.3.2
Performing Provider Name: Titus Regional Medical Center ("TRMC") 138913209

Project Description:
The reduction of inappropriate visits to the Emergency Room as the result of building a Family Care Center in Mount Pleasant. The project is related to 138913209.1.1. The goal of this project is to reduce Level 4 and Level 5 visits to the Emergency Room as a percentage of Total Visits from the baseline of May 1, 2012 through December 31, 2012 by the end of the waiver.

Project Valuation:
Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a specialist physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional physician.





The addition of Primary Care physicians in the Family Care Center and additional hours of operation will reduce the unnecessary visits to the emergency room by our residents. The current Level 4 and Level 5 visits to our emergency room are approximately 30% resulting in approximately 6,598 visits which have the potential to be treated in other settings. Assuming a 5% reduction in the Level 4 and Level 5 visits, TRMC projects an estimated cost savings of approximately $250,000 per year.

Savings - Reduction Level IV & V

Total ED Visits (annual)	21,993
Current Avg Level 4 or Below	30%
ED Visits Level 4 or Below	6,598
Reduction of Level 4 or Below	5.0%
Estimated ED Visits Avoided	330
Average ED Visit	$750
Estimated Annual Savings	**$247,416**

The charts and data above value Primary Care Physicians in Family practice at $1.625 million per year. In addition, the implementation of a Family Care Center will result in at least $250,000 per year in cost of savings. Accordingly, TRMC's average DSRIP funding request of approximately $1,337,408 per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

138913209.3.2	3.IT-9.2	ED appropriate utilization.	
Titus Regional Medical Center			138913209
Related Category 1 or 2 Projects:	**138913209.1.1**		
Starting Point/Baseline:	*May 1, 2012 – December 31, 2012*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [2 *P-1*]: Documentation of project planning approved by the CEO. **Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $41,492**	**Process Milestone 2 P-2**: Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1 [*P-5*]: Documentation of findings and action plans created based on findings. **Process Milestone 2 Estimated Incentive Payment: $48,095**	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization. Metric 1 [IT-9.2]: Reduce all ED visits. Numerator: Level 4 and Level 5 Visits in the emergency room Denominator: Total Level visits in the Emergency Room. Baseline: Emergency Room visits from May 1, 2012 through December 31, 2012. Goal: Reduce the % of Level 4 and Level 5 visits in total to baseline. **Outcome Improvement Target 1 Estimated Incentive Payment*:* $77,176**	Outcome Improvement Target 2 [IT-9.2]: ED appropriate utilization. Metric 1 [IT-9.2]: Reduce all ED visits. Numerator: Level 4 and Level 5 Visits in the emergency room Denominator: Total Level visits in the Emergency Room. Baseline: Emergency Room visits from May 1, 2012 through December 31, 2012. Goal: Reduce the % of Level 4 and Level 5 visits in total to baseline. **Outcome Improvement Target 2 Estimated Incentive Payment*:* $184,551**
Year 2 Estimated Outcome Amount: $41,492	**Year 3 Estimated Outcome Amount: $48,095**	**Year 4 Estimated Outcome Amount: $77,176**	**Year 5 Estimated Outcome Amount: $184,551**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $351,314			

Outcome Measure (Improvement Target): IT-5.2 – Per episode cost of care.
Unique RHP Project Identification Number: 138913209.3.3
Performing Provider Name: Titus Regional Medical Center ("TRMC") 138913209

Project Description:
The reduction per episode cost of care related to congestive heart failure. The project is related to 138913209.2.1. The goal of this project is to reduce the per episode cost of care related to congestive heart failure based on the cost accounting system's baseline data by the end of the waiver.

Outcome Measure Description:
To demonstrate improved cost savings TRMC has selected Outcome Domain – 5: Per episode cost of care; Target: 5.2 Improved cost savings: Demonstrate cost savings in care delivery.

Process Milestones:
The team will first begin the process of assessing the effectiveness of the selecting the redesign of cost containment. Selected quality process milestones include:
DY2
(1) project planning and (2) development/testing data systems

DY3
(3) establishment of baseline rates, (4) performance improvement and (5) dissemination of findings and lessons learned to stakeholders.

Outcome Improvement Targets for each year:
The baseline and improvement targets for DY4 and DY5 will be set in DY 3. The analysis tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures.

Rationale:
Process milestones were chosen due to the lack of accurate reports or no information. Current resources and processes were not available to accurately measure and monitor data. The analysis tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures.

Project Valuation:
The value of this project is based on the fact that it will allow TRMC to accurately measure the costs of its health care services. As a result, TRMC will be able to better manage and improve the efficiency and cost effectiveness of its health care services. This will directly impact the community need to increase the efficiency and effective of health care services. This project and its positive results are designed to be inherently sustainable. Implementation of cost accounting will provide the ability to continue measuring the efficiency and cost effectiveness of care. TRMC will continue to measure its cost effectiveness and make improvements into the future. By tracing trends over time and against national best practice benchmarks, this project

will allow for meaningful improvements in care patterns, evidence based medicine, and business practices. Improvements become possible across the continuum of care in multiple disciplines. The resulting cost savings will create savings to the health care system and low income patients in NE Texas. Decreasing the cost of health care will drive secondary impacts to the region such as increased use of preventive health care services and use of health care services in an appropriate environment.

The implementation of a cost accounting system will require the purchase of a cost accounting software and required hardware components estimated at approximately $750,000. In addition, the installation of the system and process will require considerable amount of hospital financial staff time to develop the processes and data which will be used in the cost accounting process.

TRMC recorded $65.8 million in operating expenses in fiscal 2012. Salaries and agency costs were $27.5 million or 42% of the total operating expenses. Supplies resulted in $9.7 million or 15% of these expenses. Every 1% decrease in total expenses results in savings to the community of $658,000.

The financial impact and costs above are greater than TRMC's average DSRIP funding request for this project of approximately $721,400 per year (including Category 1 and 3) so that the Medicare program accrues a net benefit.

138913209.3.3	3.IT-5.2	Per episode cost of care	
Titus Regional Medical Center			138913209
Related Category 1 or 2 Projects:	**138913209.2.1**		
Starting Point/Baseline:	*No baseline*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve cost savings. Goal: Documentation of project planning approved by the CEO. **Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $82,985**	**Process Milestone 2 P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders. Metric 1 [P-*5*]: Documentation of findings and action plans created based on findings. **Process Milestone 2 Estimated Incentive Payment: $96,190**	**Outcome Improvement Target 1** [IT-5.2]: Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Metric 1 [IT-5.2]: Measure improvement per episode cost of care related to congestive heart failure. Numerator: Total Costs for Congestive Heart Failure Denominator: Total number of episodes of Congestive Heart Failure in one month/year. Data Source: Cost Accounting Baseline: Per Episode Cost of Care for DY 3 Goal: Demonstrate cost savings in Per Episode Cost of Care **Outcome Improvement Target 1 Estimated Incentive Payment*:* $154,352**	**Outcome Improvement Target 2** [IT-5.2]: Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Metric 1 [IT-5.2]: Measure improvement per episode cost of care related to congestive heart failure. Numerator: Total Costs for Congestive Heart Failure Denominator: Total number of episodes of Congestive Heart Failure in one month/year. Data Source: Cost Accounting Baseline: Per Episode Cost of Care for DY 3 Goal: Demonstrate cost savings in Per Episode Cost of Care **Outcome Improvement Target 2 Estimated Incentive Payment*:* $369,102**
Year 2 Estimated Outcome Amount: $82,985	**Year 3 Estimated Outcome Amount: $96,190**	**Year 4 Estimated Outcome Amount: $154,352**	**Year 5 Estimated Outcome Amount: $369,102**

138913209.3.3	3.IT-5.2	Per episode cost of care	
Titus Regional Medical Center			138913209
Related Category 1 or 2 Projects:	**138913209.2.1**		
Starting Point/Baseline:	*No baseline*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $702,628			

Outcome Measure (Improvement Target): IT-3.3 – Diabetes 30 day readmission rate.
Unique RHP Project Identification Number: 138913209.3.4 (Pass 2)
Performing Provider Name: Titus Regional Medical Center ("TRMC") 138913209

Project Description:
The goal of this project is to reduce the Diabetes 30 day readmission rate by the end of the waiver. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.

Process Milestones:
The team will first begin the process of assessing the effectiveness of the selecting the project goal and defining required statistics. Selected quality process milestones include:
DY2
(1) project planning;

DY3
(2) establishment of baseline rates.

Outcome Improvement Targets for each year:
The baseline and improvement targets for DY4 and DY5 will be set in DY 3. The analysis tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures.

Project Valuation:
American Association of Diabetes Educators published a fact sheet in 2010 detailing the average savings from a patient receiving diabetes education to be $918 per year. In addition, the study showed the hospitalization rate for patients with no educational visits to be 38.1 per person per 100 years while the rate of patients with educational visits to be 25.0 per person per 100 years with education.

Savings - Diabetes Education	
Patients Seen By Diabetes Education	205
Average Savings per Patient	$918
Estimated Annual Savings	**$188,190**

Medical Group Management Association's 2011 Physician Compensation and Production Survey calculated the mean for an endocrinologist's collections for professional charges to be approximately $417,000 per year.

The charts and data above value Neurology at $417,000 per year and cost of savings of approximately $190,000 per year. Accordingly, TRMC's average DSRIP funding request of

approximately $172,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

138913209.3.4	3.IT-3.3	Diabetes 30 Day Readmission Rate	
Titus Regional Medical Center			138913209
Related Category 1 or 2 Projects:	**138913209.1.2**		
Starting Point/Baseline:	*DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve cost savings. Goal: Documentation of project planning approved by the CEO. **Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $16,151**	**Process Milestone 2 P-2:** Establish baseline rates. Metric 1 [P-*2*]: Documentation of baseline rates. **Process Milestone 2 Estimated Incentive Payment: $19,151**	**Outcome Improvement Target 1** [IT-3.3]:Diabetes 30 Day Readmission Metric 1 [IT-3.3]: Diabetes 30 Day Readmission Rate. Numerator: The number of readmissions (>= 18 years old) for any cause, within 30 days of discharge from the index diabetes admission. Denominator: The number of admissions (>= 18 years old) for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. Data Source: Registry, EHR, claims or other Performing Provider source Baseline: Readmission Rate for DY 3 Goal: Improvements of Diabetes 30 Day Readmission Rate to baseline. **Outcome Improvement Target 1 Est Incentive Payment*:* $31,309**	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30 Day Readmission Metric 1 [IT-3.3]: Diabetes 30 Day Readmission Rate. Numerator: The number of readmissions (>= 18 years old) for any cause, within 30 days of discharge from the index diabetes admission. Denominator: The number of admissions (>= 18 years old) for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission. Data Source: Registry, EHR, claims or other Performing Provider source Baseline: Readmission Rate for DY 3 Goal: Improvements of Diabetes 30 Day Readmission Rate to baseline. **Outcome Improvement Target 2 Est Incentive Payment*:* $75,405**
Year 2 Estimated Outcome Amount: $16,151	**Year 3 Estimated Outcome Amount: $19,151**	**Year 4 Estimated Outcome Amount: $31,309**	**Year 5 Estimated Outcome Amount: $75,405**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $142,016			

Outcome Measure (Improvement Target): IT-6.1 – Percent improvement over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information.
Unique RHP Project Identification Number: 138913209.3.5 (Pass 3)
Performing Provider Name: Titus Regional Medical Center ("TRMC") 138913209

Project Description:
The goal of this project is to improve the patient satisfaction scores of patients in the Emergency Room related to wait time and time to discharge.

Process Milestones:
The team will first begin the process of assessing the effectiveness of the selecting the project goal and defining required statistics. Selected quality process milestones include:
DY2
(1) project planning.

Outcome Improvement Targets for each year:
The improvement targets for DY3, DY4 and DY5 will be compared against the Patient Satisfaction Scores for calendar year 2012. Calendar year 2012 will be the last full year before the implementation of the Rapid Medical Evaluation ("RME").

Project Valuation:
Appropriate level of care is critical to ensure the patient's Emergency Room experience is efficient and cost effective. In our current patient flow, resources are not adequately proportioned in a cost effective manner. The implementation of the RME will allow our Emergency Room personnel to staff for the appropriate level of care improving our cost effectiveness. Assuming the modification to the RME flow improved the cost for the appropriate level of care by 2.5%, the annual savings would be approximately $234,000:

Savings - RME Patient Flow	
Total ED Visits (annual)	21,993
Avg Level 3 or Below	85%
ED Visits Impacted	18,694
Average ED Visit	$500
Estimated ED Charges	$9,346,843
% Savings - RME Flow	2.5%
Estimated Annual Savings	**$233,671**

The chart above calculates annual savings of at least $234,000 per year. Accordingly, TRMC's average DSRIP funding request of approximately $151,924 per year (including Category 2 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

138913209.3.5	6.IT-6.1 (1)	Percent improvements over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information.	
Titus Regional Medical Center			138913209
Related Category 1 or 2 Projects:	**138913209.2.2**		
Starting Point/Baseline:	*Calendar Year 2012*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve cost savings. Data Source: Business plan approved by CEO. Baseline: None Goal: Documentation of project planning approved by the CEO. **Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,269**	**Outcome Improvement Target 1** [IT-6.1]: Percent improvements over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information. Metric 1 [IT-6.1] (1): Patient satisfaction survey related to timely care, appointments, and information. Data Source: Patient Survey Baseline: Calendar Year 2012 Goal: Increase in percent improvements. **Outcome Improvement Target 1 Est Incentive Payment*:* $16,919**	**Outcome Improvement Target 2** [IT-6.1]: Percent improvements over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information. Metric 1 [IT-6.1] (1): Patient satisfaction survey related to timely care, appointments, and information. Data Source: Patient Survey Baseline: Calendar Year 2012 Goal: Increase in percent improvements. **Outcome Improvement Target 2 Est Incentive Payment*:* $27,660**	**Outcome Improvement Target 3** [IT-6.1]: Percent improvements over baseline of patient satisfaction scores. (1) Establish if patients are getting timely care, appointments, and information. Metric 1 [IT-6.1] (1): Patient satisfaction survey related to timely care, appointments, and information. Data Source: Patient Survey Baseline: Calendar Year 2012 Goal: Increase in percent improvements. **Outcome Improvement Target 3 Est Incentive Payment*:* $66,617**
Year 2 Estimated Outcome Amount: $14,269	**Year 3 Estimated Outcome Amount: $16,919**	**Year 4 Estimated Outcome Amount: $27,660**	**Year 5 Estimated Outcome Amount: $66,617**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $125,465			

Outcome Measure (Improvement Target): IT-3.7 – Stroke (CVA) 30 day readmission rate.
Unique RHP Project Identification Number: 138913209.3.6 (Pass 3b)
Performing Provider Name: Titus Regional Medical Center ("TRMC") 138913209

Project Description:
The goal of this project is to reduce the Stroke (CVA) 30 day readmission rate by the end of the waiver. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.

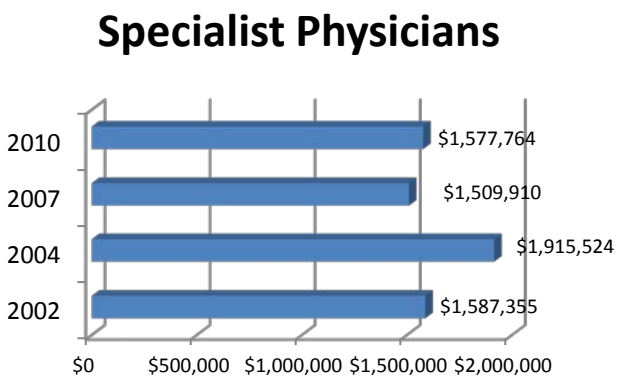
Process Milestones:
The team will first begin the process of assessing the effectiveness of the selecting the project goal and defining required statistics. Selected quality process milestones include:
DY2
(1) project planning;

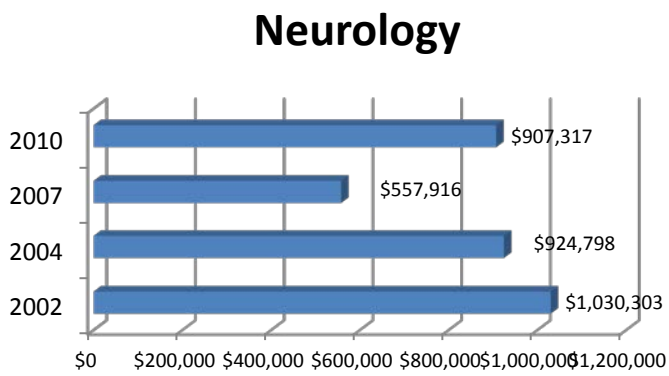
DY3
(2) establishment of baseline rates.

Outcome Improvement Targets for each year:
TRMC has selected OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs). IT-3.7: Stroke (CVA) 30 day readmission rate.

TRMC plans to engage in project planning during DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for the percentage. TRMC plans to reduce readmission rates by 5% and 10% to baseline in demonstration years 4 and 5, respectively.

Outcome Measure Valuation:
Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a specialist physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional specialist.





The 2011 Medical Group Management Association published Physician Gross Charges (TC/NPP Excluded) in their "Physician Compensation and Production Survey: 2011 Report based on 2010 Data" for the 75th percentile for Neurology at $1,012,165.

Per the most recent spending report from the Center for Medicare and Medicaid Studies (CMS), the cost of care in the first 30 days following a stroke is estimated at $13,000 in mild cases and $20,00 in severe cases with the lifetime cost of a stroke approximately $140,000. The bulk of those costs comes in the form of chronic care and rehabilitation. Over a 4-year period in 1996, a study of 414 Medicare patients demonstrated a steady decline of initial hospital length of stay from 7.0 to 4.6 days due to the presence of stroke support team. During this same period of time, there was a decline in total hospital charges from $14,076 to $10,740 per patient. This study projected a cost savings of about $3,300 per discharge. Assuming an estimated 150 stroke patients at TRMC projects an estimated cost savings of approximately $495,000 per year.

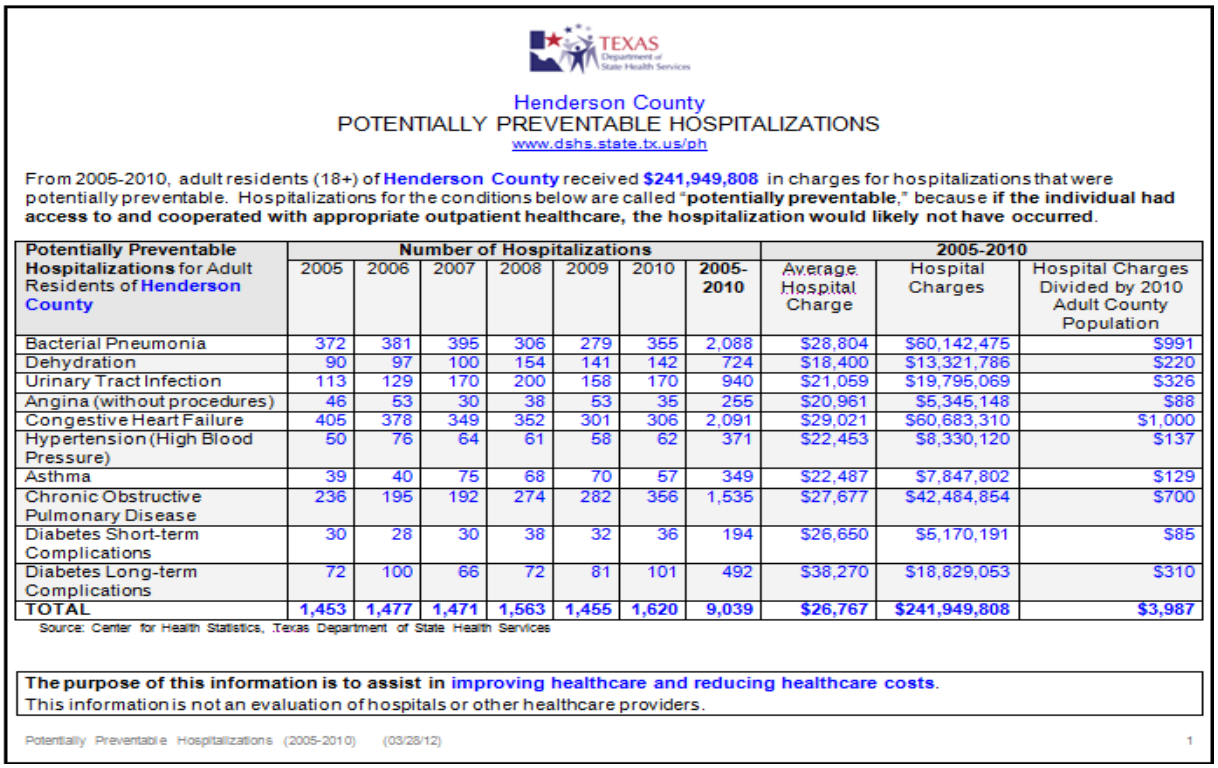
The charts and data above value Neurology at $960,000 per year and cost of savings of approximately $495,000 per year. Accordingly, TRMC's average DSRIP funding request of approximately $981,250 per year (including Category 1 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

138913209.3.6	3.IT-3.7	Stroke (CVA) 30 Day Readmission Rate	
Titus Regional Medical Center			138913209
Related Category 1 or 2 Projects:	**138913209.1.3**		
Starting Point/Baseline:	*DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Develop an implementation plan to improve cost savings. Goal: Documentation of project planning approved by the CEO. **Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $86,836**	**Process Milestone 2 P-2:** Establish baseline rates. Metric 1 [P-*2*]: Documentation of baseline rates. **Process Milestone 2 Estimated Incentive Payment: $112,690**	**Outcome Improvement Target 1** [IT-3.7]:Stroke (CVA) Diabetes 30 Day Readmission Metric 1 [IT-3.7]: Stroke (CVA) 30 Day Readmission Rate. Numerator: The number of readmissions (>= 18 years old) for any cause, within 30 days of discharge from the index CVA admission. Denominator: The number of admissions (>= 18 years old) for patients discharged from the hospital with a principal diagnosis of CVA and with a complete claims history for the 12 months prior to admission. Data Source: Registry, EHR, claims or other Performing Provider source Baseline: Readmission Rate for DY 3 Goal: Improvements of Stroke (CVA) 30 Day Readmission Rate to baseline by 5%. **Outcome Improvement Target 1 Est Incentive Payment*:* $181,088**	**Outcome Improvement Target 2** [IT-3.7]: Stroke (CVA) Diabetes 30 Day Readmission Metric 1 [IT-3.7]: Stroke (CVA) 30 Day Readmission Rate. Numerator: The number of readmissions (>= 18 years old) for any cause, within 30 days of discharge from the index CVA admission. Denominator: The number of admissions (>= 18 years old) for patients discharged from the hospital with a principal diagnosis of CVA and with a complete claims history for the 12 months prior to admission. Data Source: Registry, EHR, claims or other Performing Provider source Baseline: Readmission Rate for DY 3 Goal: Improvements of Stroke (CVA) 30 Day Readmission Rate to baseline by 10%. **Outcome Improvement Target 2 Est Incentive Payment*:* $433,280**
Year 2 Estimated Outcome Amount: $86,836	**Year 3 Estimated Outcome Amount: $112,690**	**Year 4 Estimated Outcome Amount: $181,088**	**Year 5 Estimated Outcome Amount: $433,280**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $813,894			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 139173209.3.1
Performing Provider & TPI: ETMC Athens 139173209

Outcome Measure Description: ETMC Athens's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 2% and 4% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Henderson County alone there were approximately 9,039 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $241M in charges.



TEXAS Department of State Health Services

Henderson County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
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From 2005-2010, adult residents (18+) of **Henderson County** received **$241,949,808** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Henderson County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	372	381	395	306	279	355	2,088	$28,804	$60,142,475	$991
Dehydration	90	97	100	154	141	142	724	$18,400	$13,321,786	$220
Urinary Tract Infection	113	129	170	200	158	170	940	$21,059	$19,795,069	$326
Angina (without procedures)	46	53	30	38	53	35	255	$20,961	$5,345,148	$88
Congestive Heart Failure	405	378	349	352	301	306	2,091	$29,021	$60,683,310	$1,000
Hypertension (High Blood Pressure)	50	76	64	61	58	62	371	$22,453	$8,330,120	$137
Asthma	39	40	75	68	70	57	349	$22,487	$7,847,802	$129
Chronic Obstructive Pulmonary Disease	236	195	192	274	282	356	1,535	$27,677	$42,484,854	$700
Diabetes Short-term Complications	30	28	30	38	32	36	194	$26,650	$5,170,191	$85
Diabetes Long-term Complications	72	100	66	72	81	101	492	$38,270	$18,829,053	$310
TOTAL	**1,453**	**1,477**	**1,471**	**1,563**	**1,455**	**1,620**	**9,039**	**$26,767**	**$241,949,808**	**$3,987**

Source: Center for Health Statistics, Texas Department of State Health Services

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Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

The chart below shows the estimated annual cost savings of a new clinic:

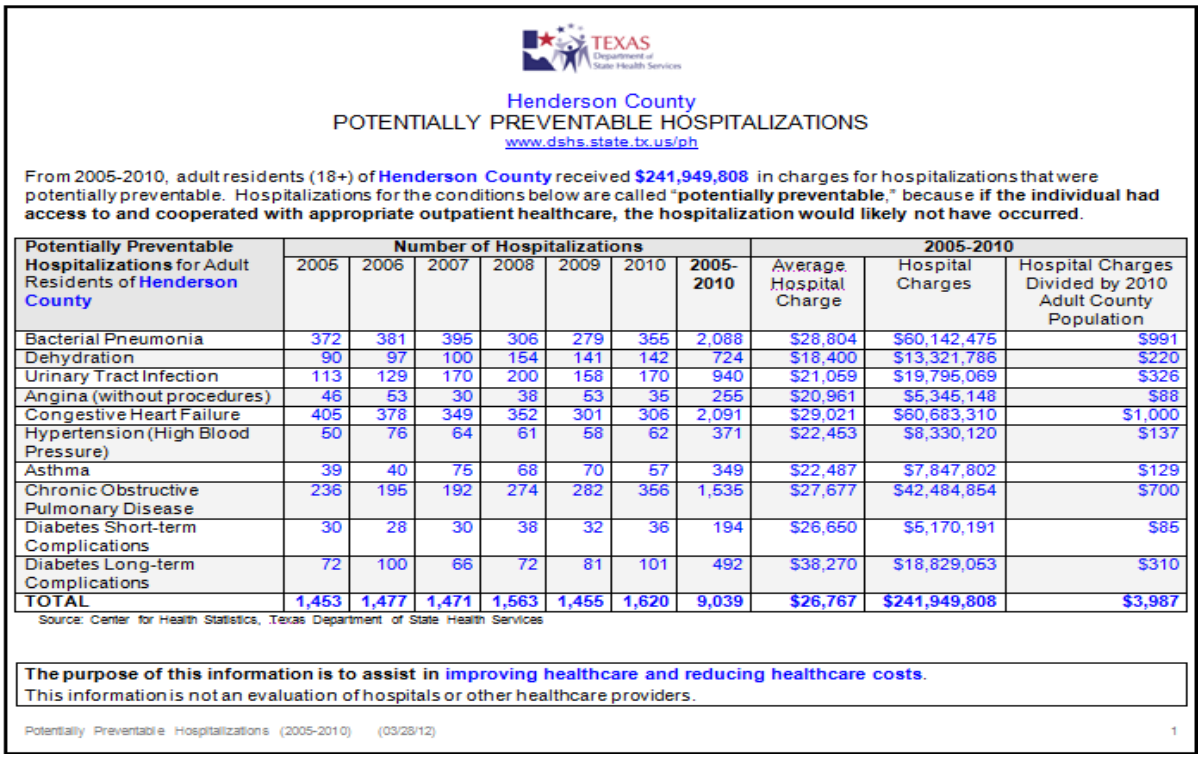
Estimated Savings New Primary Care Clinic		
Total New Clinic Patients		4,000
ED visits / year / person		0.45
Potential ED Visits		1,804
ED Visits Reduced @ 15%		271
Avg ED Payment		$425
ED Savings	**$**	**115,005**
IP Admissions / year / person		0.11
Potential IP Admissions		456
Admissions Reduced @ 18%		82
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**1,013,661**
Total Estimated Savings	**$**	**1,128,666**

139173209.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Athens			***139173209***
Related Category 1 or 2 Projects:	***139173209.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 2% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 4% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $89,105	**Process Milestone 2 Estimated Incentive Payment:** $103,285	**Outcome Improvement Target 1 Estimated Incentive Payment:** $165,736	**Outcome Improvement Target 2 Estimated Incentive Payment:** $396,325
Year 2 Estimated Total DSRIP Funding: $89,105	Year 3 Estimated Total DSRIP Funding: $103,285	Year 4 Estimated Total DSRIP Funding: $165,736	Year 5 Estimated Total DSRIP Funding: $396,325
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$754,451***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 139173209.3.2
Performing Provider & TPI: ETMC Athens 139173209

Outcome Measure Description: ETMC Athens' goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 2% and 4% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Henderson County alone there were approximately 9,039 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $241M in charges.



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Potentially Preventable Hospitalizations for Adult Residents of **Henderson County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
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Dehydration	90	97	100	154	141	142	724	$18,400	$13,321,786	$220
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Angina (without procedures)	46	53	30	38	53	35	255	$20,961	$5,346,148	$88
Congestive Heart Failure	405	378	349	352	301	306	2,091	$29,021	$60,683,310	$1,000
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TOTAL	**1,453**	**1,477**	**1,471**	**1,563**	**1,455**	**1,620**	**9,039**	**$26,767**	**$241,949,808**	**$3,987**

Source: Center for Health Statistics, Texas Department of State Health Services

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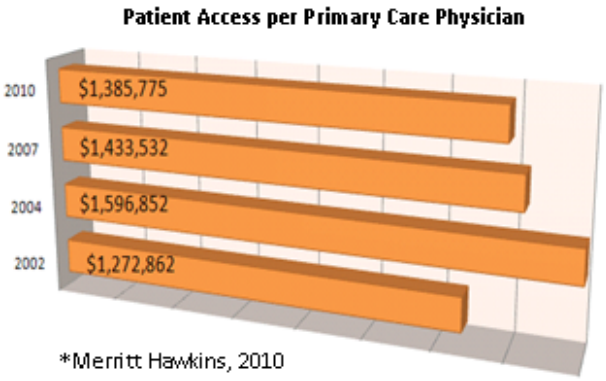
Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15% decrease in ER visits during patient-centered medical home (PCMH) pilots."

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

The charts below show the annual estimated program savings of four additional primary care physicians and access expansion:

Estimated Savings Primary Care Staffing	
Estimated Patients Served	8,000
ED visits / year / person	0.45
ED Visits	3,608
Prevented ED Visits @ 15% Reduction	**541**
ED Cost per Patient	$ 425
ED Savings	**$ 230,010**
IP Admissions / year / person	0.11
Inpatient Admissions	912
Prevented Admissions @ 18% Reduction	**164**
Avg Total Medicare Cost / Discharge	$12,354
Inpatient Savings	**$ 2,027,321**
Total Estimated Savings	**$ 2,257,331**

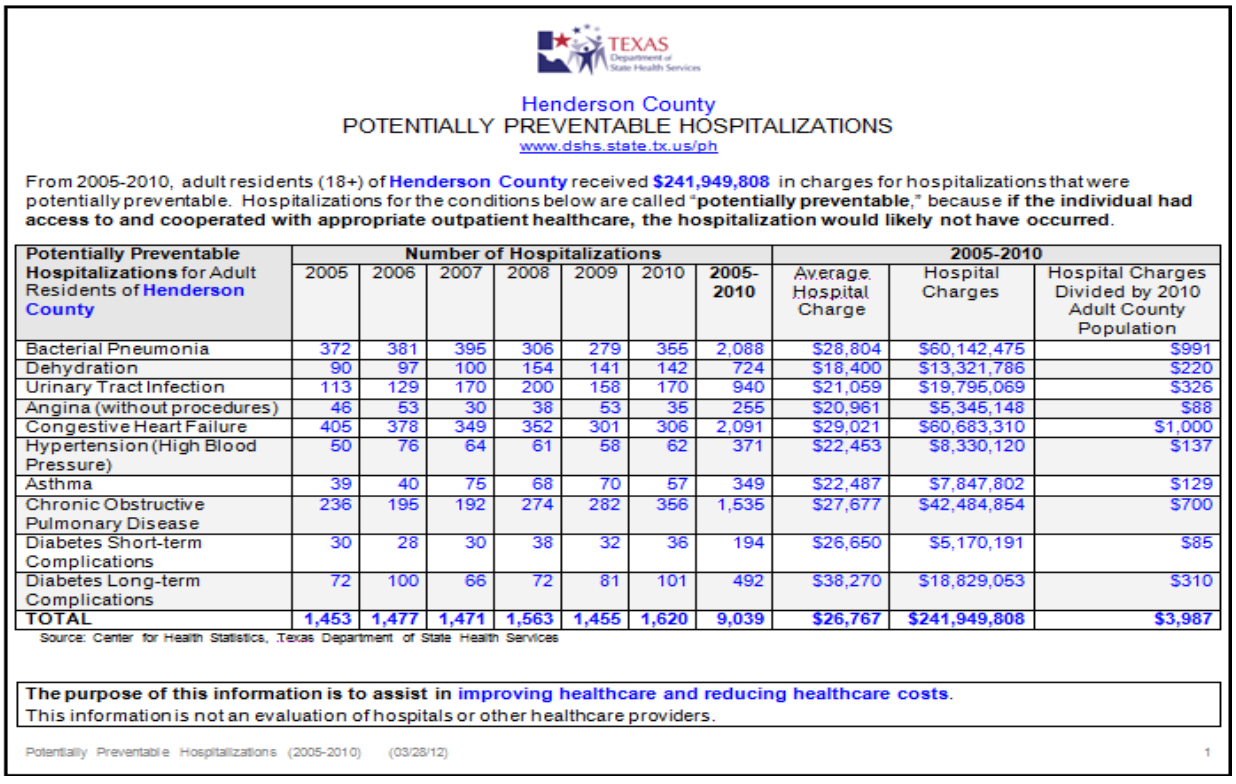


139173209.3.2	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Athens			***139173209***
Related Category 1 or 2 Projects:	***139173209.1.2***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 2% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 4% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $186,108	**Process Milestone 2 Estimated Incentive Payment:** $215,723	**Outcome Improvement Target 1 Estimated Incentive Payment:** $346,158	**Outcome Improvement Target 2 Estimated Incentive Payment:** $827,774
Year 2 Estimated Total DSRIP Funding: $186,108	Year 3 Estimated Total DSRIP Funding: $215,723	Year 4 Estimated Total DSRIP Funding: $346,158	Year 5 Estimated Total DSRIP Funding: $827,774
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$1,575,763***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 139173209.3.3
Performing Provider & TPI: ETMC Athens 139173209

Outcome Measure Description: ETMC Athens' goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through its patient navigation and ED triage protocol program (2.9.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Henderson County alone there were approximately 9,039 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $241M in charges.



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TOTAL	**1,453**	**1,477**	**1,471**	**1,563**	**1,455**	**1,620**	**9,039**	**$26,767**	**$241,949,808**	**$3,987**

Source: Center for Health Statistics, Texas Department of State Health Services

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Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: A North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." Shifting non-urgent patients to the clinic will build better habits for patients to seek primary care rather than emergency care. The relationships with primary care physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

Considering the 78% savings, the chart below values the new clinic over $1.7M per year. Accordingly, ETMC's average DSRIP funding request of approximately $1.2M per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Savings from ED Visits Triaged to Clinic		
Total ED Visits (annual)		35,741
% Clinic Appropriate		15%
Clinic Appropriate Patients		5,361
Avg ED Facility Payment	$	300
Avg ED Professional Payment	$	125
Estimated ED Savings	**$**	**2,280,580**
Clinic Payment @ 78% savings	$	501,728
Total Estimated Savings	**$**	**1,778,852**

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

139173209.3.3	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Athens			***139173209***
Related Category 1 or 2 Projects:	***139173209.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Process Milestone 1 Estimated Incentive Payment:** $113,681	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims **Process Milestone 2 Estimated Incentive Payment:** $131,771	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $211,446	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $505,632
Year 2 Estimated Total DSRIP Funding: $113,681	Year 3 Estimated Total DSRIP Funding: $131,771	Year 4 Estimated Total DSRIP Funding: $211,446	Year 5 Estimated Total DSRIP Funding: $505,632
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$962,530***			

Outcome Measure (Improvement Target): IT-3.2 – Congestive heart failure 30 day re-admission rate.
Unique RHP Outcome Identification Number: 139173209.3.4
Performing Provider & TPI: ETMC Athens 139173209

Outcome Measure Description: The goal of implementing ETMC Athens's care transitions project (2.12.1) is to reduce potentially preventable readmissions by implementing the re-engineered discharge (RED) design. Focusing on congestive heart failure (CHF) patients, the protocol will create smooth transitions of care from inpatient to outpatient settings by providing care management during this time period.

ETMC will create and implement discharge care protocols for CHF patients—much like the AHRQ designed protocol utilized in Project RED. The three core elements of Project RED are the assignment of discharge advocates, the development of a specific after-hospital care plan (AHCP), and follow-up phone calls to the patient's home. The primary outcome measure that will demonstrate our success toward that goal is to decrease the CHF 30 day re-admission rate by 8% over baseline.

Rationale: According to AHRQ, almost one-third of CHF patients are readmitted within 30 days of discharge. A 2010 AHRQ study reports that the average cost of CHF readmission is $13,000 with Medicare expending $880 million annually. Although research suggests that guideline-based management of heart failure can prevent hospitalizations, AHRQ reports that many hospitals do not consistently follow these guidelines. Patients leave the hospital not understanding why they were admitted, what was done for them in the hospital, and how to care for themselves once released. In particular, patients often leave not knowing what medicines they should and should not be taking, what symptoms to look out for, and who to contact for problems. This lack of knowledge frequently causes patients to be readmitted, causing needless suffering and preventable health care costs.

The three core elements of a discharge advocate, the AHCP, and the follow-up phone call will provide patient-centered education, comprehensive discharge planning, and post-discharge reinforcement in a practical and easily applied method. Creating a coordinated transition from inpatient service to home will have multiple benefits to patient experience and safety. With timely and quick post-hospital stay follow-up, problems with understanding and deterioration in clinical health status can be quickly identified and addressed, in most cases over the phone. For patients who have been recently hospitalized, the lack of follow-up appointments and information regarding how to keep themselves healthy puts them at risk for readmission. Reducing expensive and unnecessary readmissions will free resources for care at more appropriate levels.

When a patient's transition is less than optimal, the repercussions can be far-reaching — hospital readmission, an adverse medical event, and even mortality. Patients cannot fully participate in their care during and after hospital stays without sufficient understanding of their diagnoses, medication, and self-care needs. Additionally, poorly designed discharge processes

create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home and community-based services.

Outcome Measure Valuation: Creating a coordinated transition from inpatient service to home will have multiple benefits to patient experience and safety. With timely and quick post-hospital stay follow-up, problems with understanding and deterioration in clinical health status can be quickly identified and addressed, in most cases over the phone. For patients who have been recently hospitalized, the lack of follow-up appointments and information regarding how to keep themselves healthy puts them at risk for readmission. Reducing expensive and unnecessary readmissions will free resources for care at more appropriate levels.

A trial study published by the *Annals of Internal Medicine* and the National Institutes of Health on the re-engineered hospital discharge program shows a significant reduction in readmissions and cost. The trial hospital realized a 34% lower total cost of care for the RED intervention group of patients. "The RED intervention [also] decreased hospital utilization (combined emergency department visits and readmissions) within 30 days of discharge by about 30%. More intervention group participants reported seeing their PCP for follow-up within 30 days and reported higher levels of preparedness for discharge. In addition, the intervention was successful in reducing hospital utilization among participants who frequently used hospital services." The estimated annual cost savings for CHF patients is shown below:

Estimated Savings from CHF Post-Discharge Support	
Annual CHF Admissions	655
% CHF Readmissions*	30%
CHF Readmissions	197
Cost per CHF Readmission*	$ 13,000
Cost of CHF Readmissions	**$ 2,554,500**
% Decrease in Readmissions	10%
Prevented Readmissions	20
Estimated Annual Savings	**$ 255,450**

* AHRQ

(Jack MD, Brian W., et al (2009). Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial. *Annals of Internal Medicine*, 150(3), 178-187.)

139173209.3.4	***3.IT-3.2***	**CHF 30 Day Re-Admission Rate**	
ETMC Athens			***139173209***
Related Category 1 or 2 Projects:	***139173209.2.2***		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1:P-2 Establish baseline rate for CHF readmission rates in the target areas. **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Metric:** Documentation of baseline metrics for project plans **Data Source**: EHR, Registry, Claims **Milestone 1 Estimated Incentive Payment:** $ 25,183	**Outcome Improvement Target 1: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 4% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 29,191	**Outcome Improvement Target 2: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission. **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 6% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 46,841	**Outcome Improvement Target 3: IT-3.2** Congestive Heart Failure 30 day readmission rate **Numerator:** The number of readmissions (for patients 18 years and older), for any related cause, within 30 days of discharge from the index HF admission **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. **Improvement Target:** Achieve 8% reduction in readmission rates from baseline levels for target population (calculated as a new number minus baseline, divided by baseline). **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 3 Estimated Incentive Payment:** $ 112,010
Year 2 Estimated Total DSRIP Funding (add each milestone): $ 25,183	Year 3 Estimated Total DSRIP Funding: $29,191	Year 4 Estimated Total DSRIP Funding: $46,841	Year 5 Estimated Total DSRIP Funding: $112,010
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$213,224***			

Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores
Unique RHP Outcome Identification Number: 139173209.3.5
Performing Provider & TPI: ETMC Athens 139173209

Outcome Measure Description: The goal of implementing the patient care experience project (139173209.2.3) is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, ETMC is targeting long term improvement in HCAHPS scores through the implementation of a facility wide, transformative program. The primary outcome measure that will demonstrate our success toward that goal is to increase the facility's "overall" HCAHPS score by 10% over baseline by DY 5 as measured by an objective outsource vendor (139173209.3.5).

Rationale: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

The real challenge for a regional system like ETMC is to identify pockets of innovation in the system that are dramatically improving quality, cost and satisfaction and transport those findings and processes around the system. A recent article suggests that one way to improve cost, quality and satisfaction is to develop more rigorous discharge processes, especially in the area of medication reconciliation and patient education. Dr. Clancy's article and other research also cite myriad programmatic interventions from around the country that aim to improve quality, cost and satisfaction.

Clancy, "Reengineering the Hospital Discharge Process: A protocol to improve patient safety, reduce cost and boost patient satisfaction." American Journal of Medical Quality, July/August 2009 vol 24, no. 344-346.

Outcome Measure Valuation: ETMC's implementation of a rigorous patient satisfaction improvement program is expected to have a measureable impact on patient safety, quality and cost. As described in the matrix below, the best aggregate measure of these items will be a system-wide improvement in percentile ranking of patient satisfaction scores at all facilities.

One specific impact of improved patient satisfaction is in the area of improving the hospital discharge process. Research in this area suggests that improved medication reconciliation, and post discharge follow-ups may have an impact on downstream re-admissions for certain target populations.

As shown in the table below, a modest 10% decrease in readmission rate for Medicare patients (i.e. from 18% to 16.2%) could be mean a savings of as much as $1.154M to the Medicare Program. Accordingly, ETMC's average DSRIP funding request of approximately $625k per year (Category 2 and 3) is targeted to be less than the savings so that the Medicare program accrues a net benefit.

Estimated Savings from Patient Experience Improvement	
Annual Discharges	6680
% Medicare Readmissions*	18%
Readmissions	1202
Medicare Cost per Readmission*	$ 9,600
Cost of Readmissions	**$ 11,543,040**
% Decrease in Readmissions	10%
Prevented Readmissions	120
Estimated Annual Savings	**$ 1,154,304**

* AHRQ

139173209.3.5	***3.IT-6.1***	**Percent improvement over baseline of patient satisfaction scores**	
ETMC Athens			***139173209***
Related Category 1 or 2 Projects:	***139173209.2.3***		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate for ETMC's overall patient satisfaction. Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Metric:** Documentation of baseline top box (9-10) score for overall hospital rating domain **Data Source**: ETMC Athens HCAHPS survey data as currently administered by Press Ganey and Associates.	**Outcome Improvement Target 1: IT-6.1** Percent improvement over baseline of patient satisfaction scores Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Improvement Target:** 5% improvement over baseline of top box (9-10) score for overall hospital rating domain, calculated as (new # -baseline) /baseline **Data Source:** ETMC Athens HCAHPS survey data as currently administered by Press Ganey and Associates.	**Outcome Improvement Target 2: IT-6.1** Percent improvement over baseline of patient satisfaction scores Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Improvement Target:** 10% improvement over baseline of top box (9-10) score for overall hospital rating domain, calculated as (new # -baseline) /baseline **Data Source:** ETMC Athens HCAHPS survey data as currently administered by Press Ganey and Associates.
Process Milestone 1 Estimated Incentive Payment: $ 57,712	**Process Milestone 2 Estimated Incentive Payment:** $ 66,896	**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 107,345	**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 256,694
Year 2 Estimated Total DSRIP Funding (add each milestone): $57,712	Year 3 Estimated Total DSRIP Funding: $66,896	Year 4 Estimated Total DSRIP Funding: $107,345	Year 5 Estimated Total DSRIP Funding: $256,694
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$488,646***			

Outcome Measure (Improvement Target): IT-6.1 – Percent Improvement Over Baseline of Patient Satisfaction Scores.
Unique RHP Outcome Identification Number(s): 140425362.3.1
Performing Provider: Paris Lamar County Public Health Department 140425362

Outcome Measure Description: The Paris-Lamar County Health Department's goal is to increase the number of patients who access the clinic for their primary health care needs through a series of primary care expansion initiatives (1.1.2). During DY 2, PLCHD plans to engage in project planning by identifying current capacity and resources, determining timelines and documenting implementation plans. Data will be collected in DY 3 to serve as a baseline for improvement in Patient Satisfaction Scores. The Paris-Lamar County Health Department plans to improve Patient Satisfaction Scores by 10% for DY 3, DY 4 and DY 5.

Rationale: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patient's perspectives on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey is designed to create incentive for institutions to improve their quality of care. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for public investment. The truth about patient satisfaction surveys is that they can help you identify ways of improving your practice. Ultimately, that translates into better care and happier patients. Patient satisfaction surveys are designed to identify areas of strengths and weaknesses which ultimately cultivate an environment that embraces quality improvement.

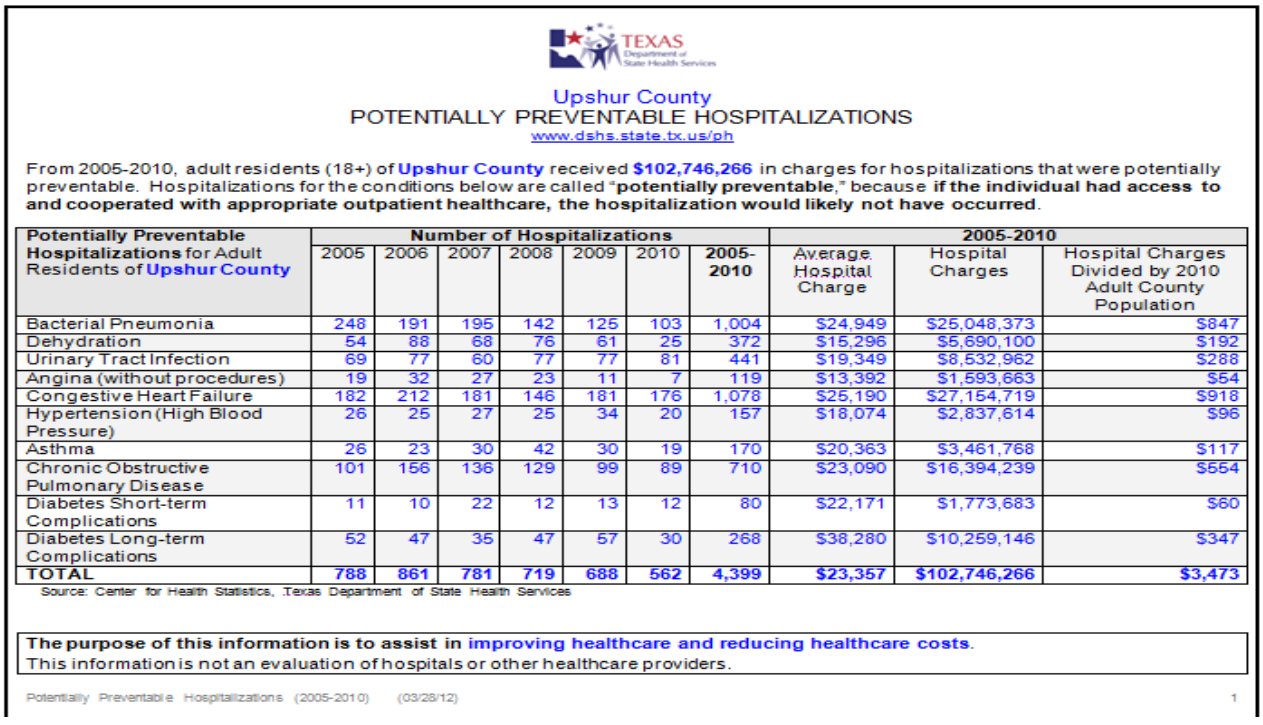
Outcome Measure Valuation: Paris-Lamar County Health Department's implementation of a rigorous patient satisfaction improvement program is expected to have a measurable impact on patient access to quality, affordable health care. The best measure of these items will be a system-wide improvement in percentile ranking of patient satisfaction scores. The valuation approach for outcome improvement target patient satisfaction is directly related to the valuation for increasing primary care capacity.
The valuation is based on the impact that expanding primary care infrastructure will have on addressing the urgent need for primary care providers. By expanding clinic space, office hours and staff, we hope to increase preventive health care services, early diagnoses, reduce preventable hospitalizations, and enhance appropriate use of emergency departments; all leading to increased health status and increased customer satisfaction.

140425362.3.1	***3.IT-6.1***	**Percent over baseline of patient satisfaction scores**	
Paris-Lamar County Health Department			***140425362***
Related Category 1 or 2 Projects:	*140425362.1.1*		
Starting Point/Baseline	***Baseline To Be Determined in DY3***		
Year 2	**Year 3**	**Year 4**	**Year 5**
Process Milestone 1 P-1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric **: Documentation of project plans** Data Source: Documentation of project plans Process Milestone 1 Estimated incentive Payment: $18,750.00	**Process Milestone 2**: P-2 Establish a baseline of patients satisfaction scores who are receiving timely care, appointments and information Numerator: Percent improvement in targeted patient satisfaction domain (for new clinic patients as of DY3) Denominator: Number of patients who were administered the survey. Metric: Documentation of patient satisfaction scores Data Source: Patient Survey Process Milestone 1 Estimated incentive Payment: $37,500.00	**Outcome Improvement Target 1: IT-6.1 Increase Patient Satisfaction Scores** Numerator: Percent improvement in targeted patient satisfaction domain (for new clinic patients as of DY3) Denominator: Number of patients who were administered the survey. Improvement Target: 10% increase in patient satisfaction scores over new baseline Data Source: Patient Survey Scores Outcome Improvement Target 1 Estimated Incentive Payment: $37,500.00	**Outcome Improvement Target 2: IT-6.1 Increase Patient Satisfaction Scores** Numerator: Percent improvement in targeted patient satisfaction domain (for new clinic patients as of DY3) Denominator: Number of patients who were administered the survey. Improvement Target: 10% increase in patient satisfaction scores over new baseline Data Source: Patient Survey Scores Outcome Improvement Target 2 Estimated Incentive Payment: $75,000
Year 2 Estimated Total DSRIP Funding: ***$18,750..00***	Year 3 Estimated Total DSRIP Funding: ***$37,500.00***	Year 4 Estimated Total DSRIP Funding: ***$37,500.00***	Year 5 Estimated Total DSRIP Funding: ***$75,000.00***
TOTAL ESTIMATED DSRIP FUNDING FOR 4-YEAR PERIOD *(add amounts of estimated DSRIP Funding for Years 2-5)**:*** **$ 168,750.00**			

Outcome Measure: IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate
Unique Outcome Identifier: 168447401.3.1
Performing Provider Name/TPI: ETMC Gilmer 168447401

Outcome Measure Description: ETMC Gilmer's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (168447401.1.1). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Dept. of State Health Services suggests that in Upshur County alone there were approximately 4,399 potentially preventable hospitalizations from 2005-2010. These patients represented more than $102M in charges.



TEXAS Department of State Health Services

Upshur County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Upshur County** received **$102,746,266** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Upshur County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	248	191	195	142	125	103	1,004	$24,949	$25,048,373	$847
Dehydration	54	88	68	76	61	25	372	$15,296	$5,690,100	$192
Urinary Tract Infection	69	77	60	77	77	81	441	$19,349	$8,532,962	$288
Angina (without procedures)	19	32	27	23	11	7	119	$13,392	$1,593,663	$54
Congestive Heart Failure	182	212	181	146	181	176	1,078	$25,190	$27,154,719	$918
Hypertension (High Blood Pressure)	26	25	27	25	34	20	157	$18,074	$2,837,614	$96
Asthma	26	23	30	42	30	19	170	$20,363	$3,461,768	$117
Chronic Obstructive Pulmonary Disease	101	156	136	129	99	89	710	$23,090	$16,394,239	$554
Diabetes Short-term Complications	11	10	22	12	13	12	80	$22,171	$1,773,683	$60
Diabetes Long-term Complications	52	47	35	47	57	30	268	$38,280	$10,259,146	$347
TOTAL	**788**	**861**	**781**	**719**	**688**	**562**	**4,399**	**$23,357**	**$102,746,266**	**$3,473**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15%

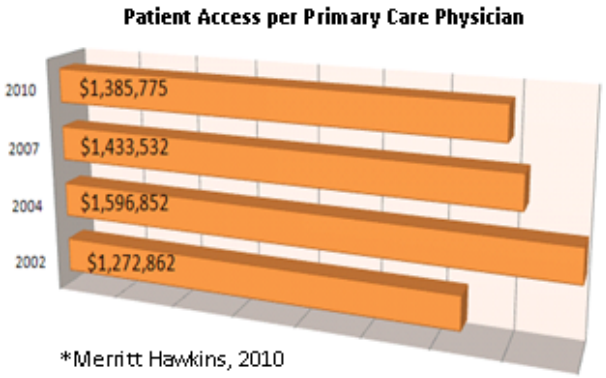
decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $790,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $500,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

The charts below show the annual estimated program savings and access expansion:

Estimated Savings Workforce Enhancement		
Estimated Patients Served		2,800
ED visits / year / person		0.45
ED Visits		1,263
Prevented ED Visits @ 15% Reduction		**189**
ED Cost per Patient	$	425
ED Savings	**$**	**80,504**
IP Admissions / year / person		0.11
Inpatient Admissions		319
Prevented Admissions @ 18% Reduction		**57**
Avg Total Medicare Cost / Discharge		$12,354
Inpatient Savings	**$**	**709,562**
Total Estimated Savings	**$**	**790,066**



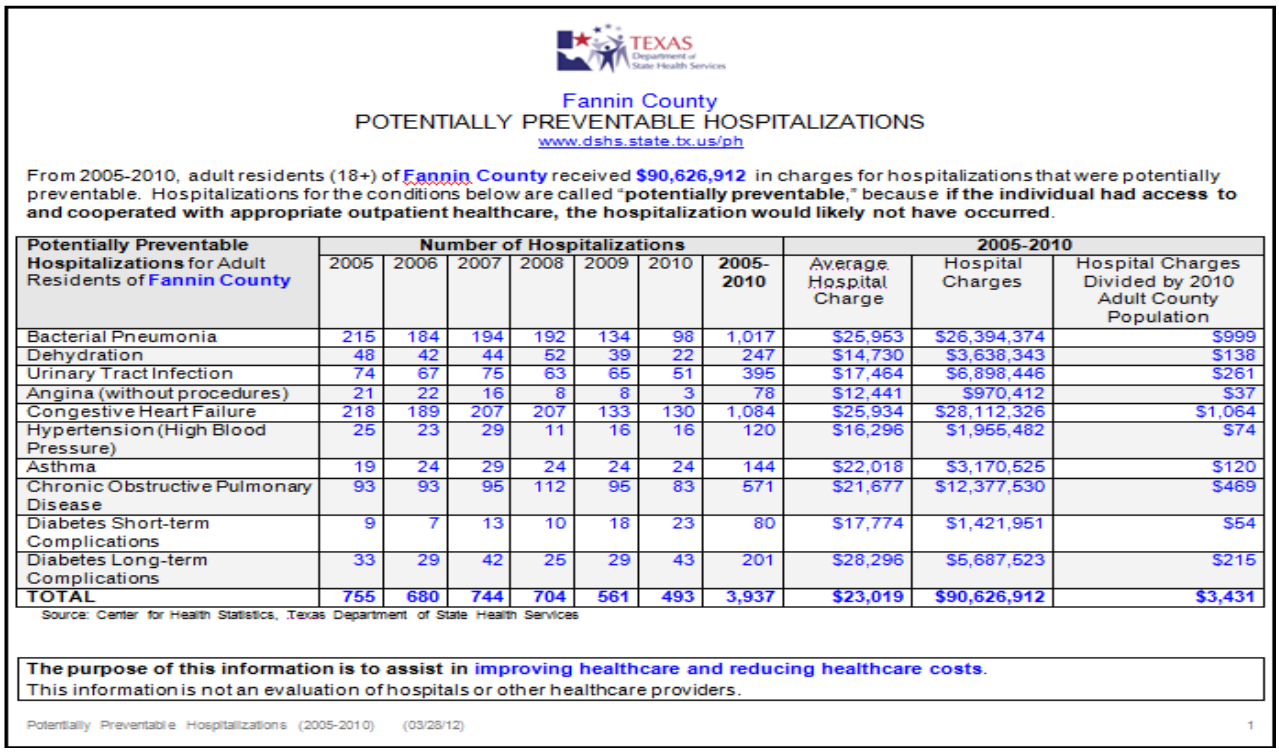
168447401.3.1	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Gilmer			***168447401***
Related Category 1 or 2 Projects:	***168447401.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $44,703	**Process Milestone 2 Estimated Incentive Payment:** $53,007	**Outcome Improvement Target 1 Estimated Incentive Payment:** $86,655	**Outcome Improvement Target 2 Estimated Incentive Payment:** $208,705
Year 2 Estimated Total DSRIP Funding: $44,703	Year 3 Estimated Total DSRIP Funding: $53,007	Year 4 Estimated Total DSRIP Funding: $86,655	Year 5 Estimated Total DSRIP Funding: $208,705
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$393,070***			

Outcome Measure: IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate

Unique Outcome ID Number: 177870603.3.1
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Outcome Measure Description: Red River Regional Hospital's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through primary care expansion initiatives (177870603.1.1). RRRH plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. RRRH plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new RRRH primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Fannin County alone there were approximately 3,937 potentially preventable hospitalizations from 2005-2010. These patients represented more than $90M in charges.



TEXAS Department of State Health Services

Fannin County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of Fannin County received **$90,626,912** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Fannin County**	**Number of Hospitalizations**						**2005-2010**			
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	215	184	194	192	134	98	1,017	$25,953	$26,394,374	$999
Dehydration	48	42	44	52	39	22	247	$14,730	$3,638,343	$138
Urinary Tract Infection	74	67	75	63	65	51	395	$17,464	$6,898,446	$261
Angina (without procedures)	21	22	16	8	8	3	78	$12,441	$970,412	$37
Congestive Heart Failure	218	189	207	207	133	130	1,084	$25,934	$28,112,326	$1,064
Hypertension (High Blood Pressure)	25	23	29	11	16	16	120	$16,296	$1,955,482	$74
Asthma	19	24	29	24	24	24	144	$22,018	$3,170,525	$120
Chronic Obstructive Pulmonary Disease	93	93	95	112	95	83	571	$21,677	$12,377,530	$469
Diabetes Short-term Complications	9	7	13	10	18	23	80	$17,774	$1,421,951	$54
Diabetes Long-term Complications	33	29	42	25	29	43	201	$28,296	$5,687,523	$215
TOTAL	**755**	**680**	**744**	**704**	**561**	**493**	**3,937**	**$23,019**	**$90,626,912**	**$3,431**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

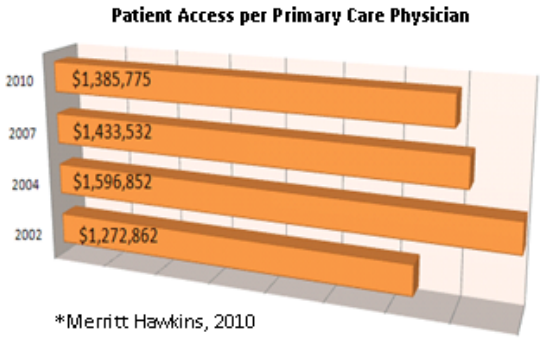
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15%

decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

The charts below value the access expansion impact of a primary care physician at $1.3M per year and decreased utilization savings at $.7M per year. Accordingly, RRRH's DSRIP funding request of approximately $684,000 per year (including Category 1 and 3) is targeted to be less than the total savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Primary Care Capacity		
Total New Clinic Patients		2,442
ED visits / year / person		0.45
Potential ED Visits		1,101
ED Visits Reduced @ 15%		165
Avg ED Payment		$425
ED Savings	**$**	**70,197**
IP Admissions / year / person		0.11
Potential IP Admissions		278
Admissions Reduced @ 18%		50
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**618,717**
Total Estimated Savings	**$**	**688,913**



177870603.3.1	***3.IT-2.11***	**Ambulatory Care Sensitive Conditions Admissions Rate**	
Red River Regional Hospital			***177870603***
Related Category 1 or 2 Projects:	***177870603.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $61,464	**Process Milestone 2 Estimated Incentive Payment:** $72,881	**Outcome Improvement Target 1 Estimated Incentive Payment:** $119,146	**Outcome Improvement Target 2 Estimated Incentive Payment:** $286,956
Year 2 Estimated Total DSRIP Funding: $61,464	Year 3 Estimated Total DSRIP Funding: $72,881	Year 4 Estimated Total DSRIP Funding: $119,146	Year 5 Estimated Total DSRIP Funding: $286,956
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$540,447***			

Outcome Measure: IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) - NQF 0059*
Unique Outcome ID Number: 177870603.3.2
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Outcome Measure Description: Through the diabetes management program (177870603.2.1), Red River Regional Hospital plans to engage in project planning for decreasing HbA1c poor control (>9.0%) patients in the clinic during DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for the percentage of HbA1c poor control (>9.0%) patients. RRRH plans to decrease the percentage of HbA1c poor control (>9.0%) patients —RRRH clinic patients—by 4% and 8% in demonstration years 4 and 5, respectively.

Through expanded diabetes management, our clinic will decrease the percentage of clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

Rationale: Diabetes is a disease that has reached epidemic proportions across the US and Texas. According to the Kaiser Family Foundation, 9.8% of adults in Texas have been diagnosed with diabetes while 6.2% of all US adults have diabetes. According to the Centers for Disease Control (CDC) in Atlanta, diabetes was the sixth leading cause of death on U.S. death certificates in 2006. Overall, the risk for death among people with diabetes is about twice that of people without diabetes of similar age. Diabetes is also the leading cause of new cases of blindness, kidney failure, and non-traumatic lower-extremity amputations among adults.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

If current trends continue, 1 in 3 Americans will develop diabetes sometime in their lifetime, and those with diabetes will lose an average of 10-15 years of life. African American, Hispanic, American Indian, and Alaska Native adults are twice as likely as white adults to have diabetes. Therefore, the large Hispanic population is at risk throughout the East Texas communities. The diabetes epidemic is only getting worse, so implementing the management program is essential to serving the health needs of East Texas.

Outcome Measure Valuation: In a 2010 diabetes disease management study by The American Journal of Managed Care, the intervention group decreased their all-cause total medical costs

by $984.87 per member per year (PMPY). They study's conclusion stated that "a disease management program for high-risk patients with diabetes and CAD was effective in reducing hospital inpatient admission and total costs in a Medicare Advantage population."

Applying this cost savings data, the chart below values diabetes management over $266,000 per year. Accordingly, RRRH's average DSRIP funding request of approximately $254,000 per year (including Category 2 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings from Diabetes Management	
Total Clinic Patients	2,761
% Diabetic Patients	9.8%
Clinic patients with diabetes	271
Annl. Savings per Diabetic patient*	$ 984.87
Estimated Annual Savings	**$266,498**

*American Journal of Managed Care

(Rosenzweig, et. al. Diabetes Disease Management in Medicare Advantage Reduces Hospitalizations and Costs. *The American Journal of Managed Care.* 2010;16(7):e157-e162)

177870603.3.2	***3.IT-1.10***	**Diabetes care: *HbA1c poor control (>9.0%)***	
Red River Regional Hospital			***177870603***
Related Category 1 or 2 Projects:	***177870603.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Numerator**:** Number of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator**:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Metric:** Documentation of baseline percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. **Data Source:** EHR, Registry, Claims, Administrative clinical data	**Outcome Improvement Target 1: IT-1.10** Decrease percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Numerator**:** Number of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator**:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Improvement Target:** 4% decrease in percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Calculated as (new # -baseline) /baseline **Data Source:** EHR, Registry, Claims, Administrative clinical data	**Outcome Improvement Target 2: IT-1.10** Decrease percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Numerator**:** Number of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator**:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) **Improvement Target:** 8% decrease in percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Calculated as (new # -baseline) /baseline **Data Source:** EHR, Registry, Claims, Administrative clinical data
Process Milestone 1 Estimated Incentive Payment: $ 22,881	**Process Milestone 2 Estimated Incentive Payment:** $ 27,131	**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 44,353	**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 106,823
Year 2 Estimated Total DSRIP Funding: $22,881	Year 3 Estimated Total DSRIP Funding: $27,131	Year 4 Estimated Total DSRIP Funding: $44,353	Year 5 Estimated Total DSRIP Funding: $106,823
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$201,188***			

Outcome Measure: IT-6.1 Percent improvement over baseline of patient satisfaction scores
Unique Outcome Identifier: 177870603.3.3
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Outcome Measure Description: The goal of implementing RRRH project 177870603.2.2 – "Redesign to improve the patient care experience" is to improve how the patient experiences the care and the patient's satisfaction with the care provided. More specifically, RRRH is targeting long term improvement in HCAHPS scores through the implementation of a facility wide, transformative program. The primary outcome measure that will demonstrate our success toward that goal is to increase the facility's "overall" HCAHPS score by 10% over baseline as measured by an objective outsource vendor.

Rationale: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

The real challenge for RRRH is to identify pockets of innovation that are dramatically improving quality, cost, and satisfaction and hardwire those solutions for long term success. A recent article suggests that one way to improve cost, quality, and satisfaction is to develop more rigorous discharge processes, especially in the area of medication reconciliation and patient education. Dr. Clancy's article and other research also cite myriad programmatic interventions from around the country that aim to improve quality, cost, and satisfaction.

Clancy, "Reengineering the Hospital Discharge Process: A protocol to improve patient safety, reduce cost and boost patient satisfaction." American Journal of Medical Quality, July/August 2009 vol 24, no. 344-346.

Outcome Measure Valuation: RRRH's implementation of a rigorous patient satisfaction improvement program is expected to have a measureable impact on patient safety, quality, and cost. As described in the matrix below, the best aggregate measure of these items will be percent improvement of overall patient satisfaction scores over baseline.

One specific impact of improved patient satisfaction is in the area of improving the hospital discharge process. Research in this area suggests that improved medication reconciliation, and post discharge follow-ups may have an impact on downstream re-admissions for certain target populations.

As shown in the table below, a 20% decrease in readmissions could mean a savings of as much as $303,000 per year. Accordingly, RRRH's average DSRIP funding request of approximately

$289,000 per year (Category 2 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings from Patient Experience Improvement	
Annual Discharges	879
Avg Readmissions %*	18%
Readmissions	158
Cost per Readmission*	$ 9,600
Cost of Readmissions	**$ 1,518,912**
% Decrease in Readmissions	20%
Prevented Readmissions	32
Estimated Annual Savings	**$ 303,782**

* AHRQ

177870603.3.3	***3.IT-6.1***	**Percent improvement over baseline of patient satisfaction scores**	
Red River Regional Hospital			***177870603***
Related Category 1 or 2 Projects:	***177870603.2.2***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1:P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate for RRRH's overall patient satisfaction. Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Metric:** Documentation of baseline top box (9-10) score for overall hospital rating domain **Data Source**: RRRH's HCAHPS survey data from objective outsource vendor.	**Outcome Improvement Target 1: IT-6.1** Percent improvement over baseline of patient satisfaction scores Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Improvement Target:** 5% improvement over baseline of top box (9-10) score for overall hospital rating domain, calculated as (new # -baseline) /baseline **Data Source:** RRRH's HCAHPS survey data from objective outsource vendor.	**Outcome Improvement Target 2: IT-6.1** Percent improvement over baseline of patient satisfaction scores Numerator**:** # of surveys with overall hospital rating at 9 or 10 Denominator**:** Total # of surveys completed for the overall rating domain **Improvement Target:** 10% improvement over baseline of top box (9-10) score for overall hospital rating domain, calculated as (new # -baseline) /baseline **Data Source:** RRRH's HCAHPS survey data from objective outsource vendor.
Process Milestone 1 Estimated Incentive Payment: $ 26,021	**Process Milestone 2 Estimated Incentive Payment:** $ 30,855	**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 50,441	**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 121,485
Year 2 Estimated Total DSRIP Funding (add each milestone): $26,021	Year 3 Estimated Total DSRIP Funding: $30,855	Year 4 Estimated Total DSRIP Funding: $50,441	Year 5 Estimated Total DSRIP Funding: $121,485
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$228,802***			

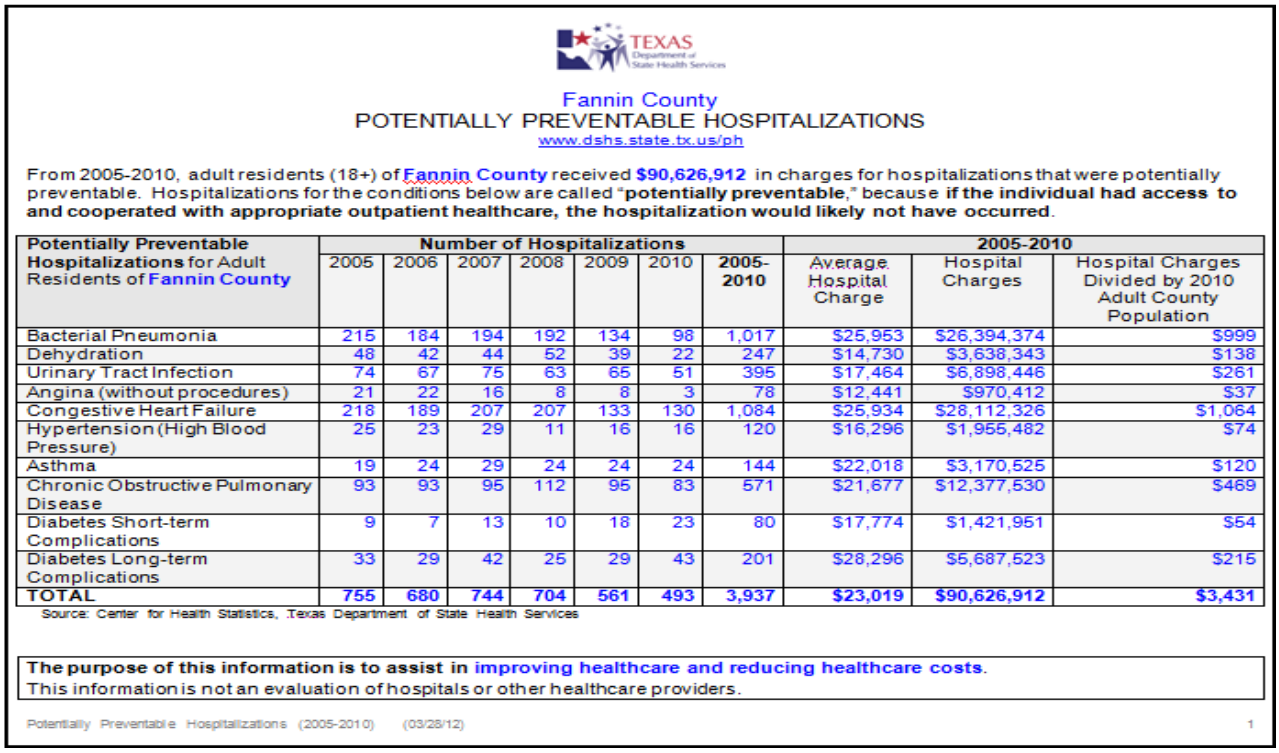
Outcome Measure (Improvement Target): IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate
Unique RHP Outcome Identification Number: 177870603.3.4
Performing Provider Name/TPI: Red River Regional Hospital 177870603

Outcome Measure Description: Establishing a structured outpatient program (SOP) for geriatric, behavioral health patients (177870603.2.3) will decrease 30 day readmissions for behavioral health/substance abuse patients. RRRH plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the 30 day readmission rate. RRRH plans to decrease 30 day readmissions for geriatric patients receiving interventions through structured outpatient therapy by 2.5% and 5% in demonstration years 4 and 5, respectively.

Rationale: Evidence based, outpatient therapies will be utilized to assist geriatric patients in the community to improve cognitive and dialectical abilities. It will assist in helping them to maintain a level of functioning in the community that allows them independence on an outpatient basis rather than inpatient basis. In addition to meeting community needs for behavioral health services and potentially preventable admissions (CN.2 and CN.4), the end result will be improved overall global functioning and a decrease in symptoms.

Research indicates that evidence based therapies are effective tools in preventing psychiatric hospital admissions and re-admissions. Adding outpatient therapy will give us the opportunity to impact the lives of persons with disabilities in a positive way. It could provide the emotional support and coping skills needed to decrease admissions to the hospital. It would improve stabilization and assist in maintaining a high level of functioning on an outpatient basis. Providing outpatient behavioral services will also prevent service area residents from traveling for their needs.

The Texas Department of State Health Services suggests that in Fannin County alone there were approximately 3,937 potentially preventable hospitalizations from 2005-2010. These patients represented more than $90M in charges. Also according to the Texas Department of State Health Services, nearly 50% of 2008 hospitalizations in Texas had a secondary diagnosis of a mental health condition. Therefore, improving the 30 day readmission rate for behavioral health patients has the potential to decrease this cost of preventable hospitalizations.



Fannin County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of Fannin County received $90,626,912 in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of Fannin County	Number of Hospitalizations						2005-2010			
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	215	184	194	192	134	98	1,017	$25,953	$26,394,374	$999
Dehydration	48	42	44	52	39	22	247	$14,730	$3,638,343	$138
Urinary Tract Infection	74	67	75	63	65	51	395	$17,464	$6,898,446	$261
Angina (without procedures)	21	22	16	8	8	3	78	$12,441	$970,412	$37
Congestive Heart Failure	218	189	207	207	133	130	1,084	$25,934	$28,112,326	$1,064
Hypertension (High Blood Pressure)	25	23	29	11	16	16	120	$16,296	$1,955,482	$74
Asthma	19	24	29	24	24	24	144	$22,018	$3,170,525	$120
Chronic Obstructive Pulmonary Disease	93	93	95	112	95	83	571	$21,677	$12,377,530	$469
Diabetes Short-term Complications	9	7	13	10	18	23	80	$17,774	$1,421,951	$54
Diabetes Long-term Complications	33	29	42	25	29	43	201	$28,296	$5,687,523	$215
TOTAL	**755**	**680**	**744**	**704**	**561**	**493**	**3,937**	**$23,019**	**$90,626,912**	**$3,431**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Outcome Measure Valuation: The cost per inpatient psychiatric bed per day is approximately $685, compared to one therapy session hour at $75. At 50 hours per patient, we project that our program will serve 50 geriatric patients per year. Providing therapy for 50 patients rather than inpatient utilization will save approximately $155,000 per year in future institutionalization costs.

Accordingly, RRRH's average DSRIP funding request of approximately $50,000 per year (including Category 2 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Annual Savings Geriatric, Behavioral Health Outpatient Therapy		
Geriatric population served		50
Therapy Hours per Year	@ 50 per client	2,500
Therapy Cost per Session		$ 75
Therapy Cost per Year		**187,500**
New population served		50
Inpatient Bed Utilization per Year	ALOS @ 10 days	10
Cost per Inpatient Psych day*		$ 685
Inpatient Bed Cost per Year		**$ 342,505**
Estimated Annual Savings		**$ 155,005**

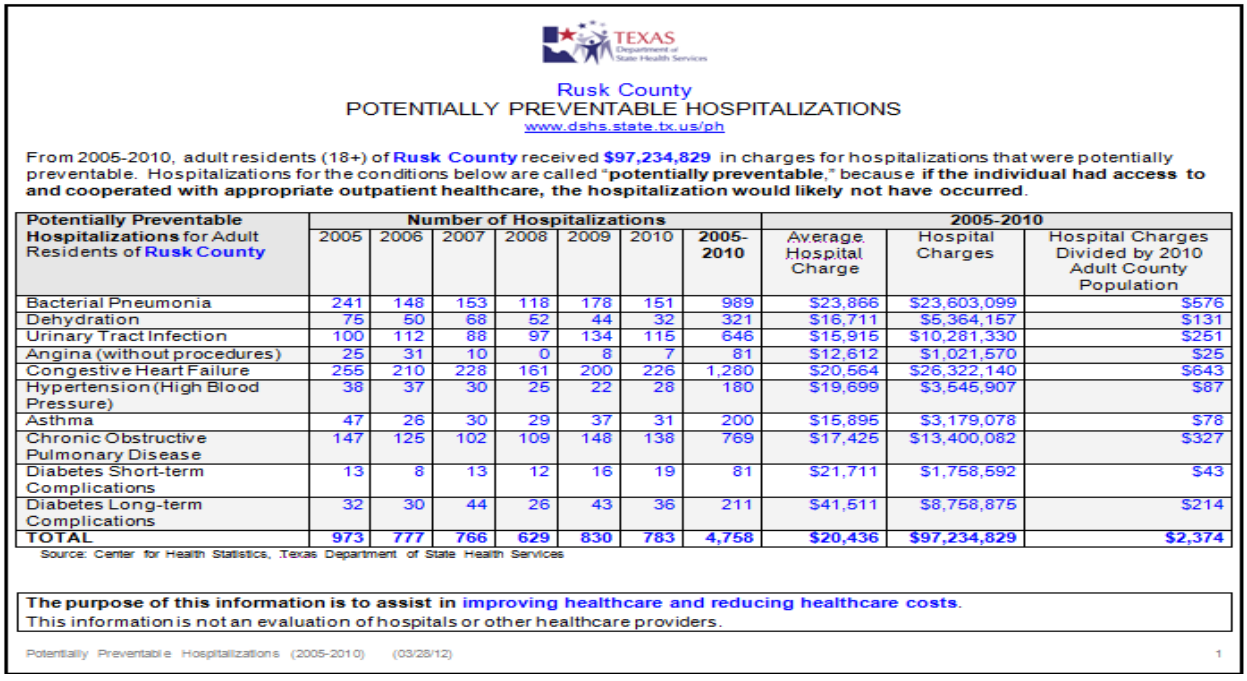
*CMS, Inpatient Psychiatric Facility Prospective Payment System, June 2011

177870603.3.4	***3.IT-3.8***	**Behavioral Health /Substance Abuse 30 day readmission rate**	
Red River Regional Hospital			***177870603***
Related Category 1 or 2 Projects:	***177870603.2.3***		
Starting Point/Baseline:	*Baseline to be determined in DY2*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc. **Milestone 1 Estimated Incentive Payment:** $ 4,040	**Process Milestone 2: P-2** Establish baseline rate of Behavioral Health /Substance Abuse 30 day readmission rate Numerator**:** The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. Denominator**:** The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission *Only the first readmission per index admission is counted. **Metric:** Documentation of baseline Behavioral Health /Substance Abuse 30 day readmission rate **Data Source**: EHR, Registry, Claims **Milestone 2 Estimated Incentive Payment:** $ 4,790	**Outcome Improvement Target 1: IT-3.8** Behavioral Health /Substance Abuse 30 day readmission rate Numerator**:** The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. Denominator**:** The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission *Only the first readmission per index admission is counted. **Improvement Target:** Achieve 2.5% reduction in readmission rate from baseline for target population, calculated as (new # -baseline) /baseline **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 7,831	**Outcome Improvement Target 2: IT-3.8** Behavioral Health /Substance Abuse 30 day readmission rate Numerator**:** The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. Denominator**:** The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission *Only the first readmission per index admission is counted. **Improvement Target:** Achieve 5% reduction in readmission rate from baseline for target population, calculated as (new # -baseline) /baseline **Data Source:** EHR, Registry, Claims **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 18,861
Year 2 Estimated Total DSRIP Funding (add each milestone): $4,040	Year 3 Estimated Total DSRIP Funding: $4,790	Year 4 Estimated Total DSRIP Funding: $7,831	Year 5 Estimated Total DSRIP Funding: $18,861
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$35,523***			

Outcome Measure (Improvement Target): IT-2.11: Ambulatory care sensitive conditions admissions rate.
Unique RHP Outcome Identification Number: 208843701.3.1
Performing Provider & TPI: ETMC Henderson 208843701

Outcome Measure Description: ETMC Henderson's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives (1.1.2). ETMC plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the Ambulatory Care Sensitive Conditions Admissions Rate. ETMC plans to decrease the Ambulatory Care Sensitive Conditions Admissions Rate—for new ETMC primary care clinic patients as of DY 3—by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Hospitalization for an ambulatory care sensitive condition (ACSC) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. The Texas Department of State Health Services suggests that in Rusk County alone there were approximately 4,758 potentially preventable hospitalizations from 2005 -2010. These patients represented more than $97M in charges.



TEXAS Department of State Health Services

Rusk County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Rusk County** received **$97,234,829** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Rusk County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	241	148	153	118	178	151	989	$23,866	$23,603,099	$576
Dehydration	75	50	68	52	44	32	321	$16,711	$5,364,157	$131
Urinary Tract Infection	100	112	88	97	134	115	646	$15,915	$10,281,330	$251
Angina (without procedures)	25	31	10	0	8	7	81	$12,612	$1,021,570	$25
Congestive Heart Failure	255	210	228	161	200	226	1,280	$20,564	$26,322,140	$643
Hypertension (High Blood Pressure)	38	37	30	25	22	28	180	$19,699	$3,545,907	$87
Asthma	47	26	30	29	37	31	200	$15,895	$3,179,078	$78
Chronic Obstructive Pulmonary Disease	147	125	102	109	148	138	769	$17,425	$13,400,082	$327
Diabetes Short-term Complications	13	8	13	12	16	19	81	$21,711	$1,758,592	$43
Diabetes Long-term Complications	32	30	44	26	43	36	211	$41,511	$8,758,875	$214
TOTAL	**973**	**777**	**766**	**629**	**830**	**783**	**4,758**	**$20,436**	**$97,234,829**	**$2,374**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

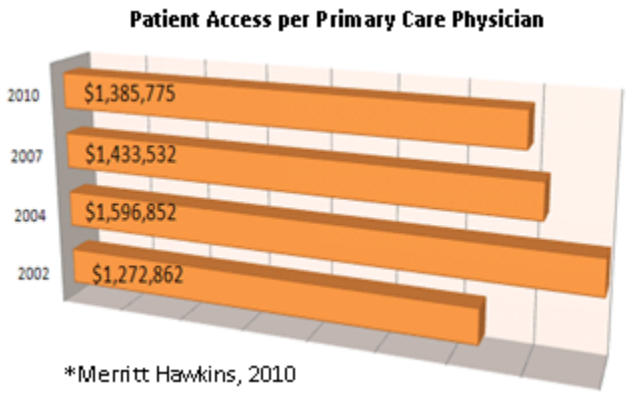
Outcome Measure Valuation: In its March 2012 Executive Newsletter, HealthGrades reported that WellPoint, Inc. members "experienced an 18% decrease in inpatient admissions and a 15%

decrease in ED visits during patient-centered medical home (PCMH) pilots." Decreasing admissions and ED visits will create a large opportunity for savings.

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a primary care physician on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional primary care physician.

After applying the decreased utilization data and physician impact, the charts below value the new clinic over at between $234,000 per year and $1.4M per year. Accordingly, ETMC's average DSRIP funding request of approximately $160,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Estimated Savings Expand Clinic Hours		
Total New Clinic Patients		833
ED visits / year / person		0.45
Potential ED Visits		376
ED Visits Reduced @ 15%		56
Avg ED Payment		$425
ED Savings	**$**	**23,945**
IP Admissions / year / person		0.11
Potential IP Admissions		95
Admissions Reduced @ 18%		17
Avg Total Medicare Cost / Discharge		$12,354
IP Admission Savings	**$**	**211,051**
Total Estimated Savings	**$**	**234,995**



208843701.3.1	*3.IT-2.11*	**Ambulatory Care Sensitive Conditions Admissions Rate**	
ETMC Henderson			***208843701***
Related Category 1 or 2 Projects:	***208843701.1.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline rate of Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Metric:** Documentation of baseline Ambulatory Care Sensitive Conditions Admissions Rate under age 75 **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 3% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-2.11** Decrease Ambulatory Care Sensitive Conditions Admissions Rate under age 75 Numerator**:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (for new clinic patients as of DY 3). Denominator**:** Total mid-year patients under age 75 (for new clinic patients as of DY 3). **Improvement Target:** 6% decrease in Ambulatory Care Sensitive Conditions Admissions Rate, calculated as (new # -baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $14,824	**Process Milestone 2 Estimated Incentive Payment:** $17,183	**Outcome Improvement Target 1 Estimated Incentive Payment:** $27,573	**Outcome Improvement Target 2 Estimated Incentive Payment:** $65,935
Year 2 Estimated Total DSRIP Funding: $14,824	Year 3 Estimated Total DSRIP Funding: $17,183	Year 4 Estimated Total DSRIP Funding: $27,573	Year 5 Estimated Total DSRIP Funding: $65,935
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$125,516***			

Outcome Measure (Improvement Target): IT-4.4 – Surgical site infections rate.
Unique RHP Outcome Identification Number: 208843701.3.2
Performing Provider & TPI: ETMC Henderson 208843701.3.2

Outcome Measure Description: ETMC Henderson's goal is to reduce the number of surgical site infections (SSI) for new general surgery cases (1.9.2). ETMC plans to develop and test data systems to measure surgical site infections (SSI) rates during DY 2. We will collect preliminary data in DY 3 to serve as a baseline for improvement in the surgical site infection (SSI) rate. ETMC plans to decrease the surgical site infection (SSI) rate —for general surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively.

We propose to increase the overall quality of care and improve the health status of our target population—general surgery patients at ETMC Henderson. Recruiting a general surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. A local general surgeon and quality improvement oversight will decrease surgical site infection (SSI) rates, which are directly related high costs due to potentially preventable hospitalizations (CN.4).

Rationale: While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity and mortality among hospitalized patients. In one study, among nearly 100,000 HAIs reported in one year, deaths were associated with SSIs in more than 8,000 cases. Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk. A successful surveillance program includes the use of epidemiologically-sound infection definitions and effective surveillance methods, stratification of SSI rates according to risk factors associated with SSI development, and data feedback.

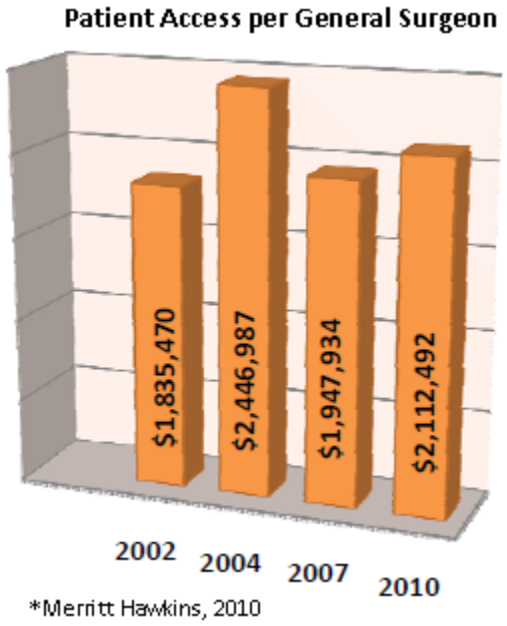
Outcome Measure Valuation: The value of decreasing SSIs is shown in the estimated burden of SSIs in acute care facilities in the United States. There are about 300,000 SSIs per year, costing the United States from $3 billion - $10 billion annually. Each SSI is associated with approximately 7-10 additional postoperative hospital days, and 2%-5% of patients undergoing inpatient surgery develop a SSI. The estimated cost per infection ranges from $11,000 - $35,000; therefore, preventing approximately 22 SSIs between DY 2-5 will produce savings greater than the 4-year total estimated DSRIP funding requested ($502,063).

(http://www.vdh.virginia.gov/epidemiology/surveillance/hai/ssi.htm "Surgical Site Infections," Virginia Department of Health. Accessed 10 Oct 2012.)

Since 2002, Merritt Hawkins—a national physician search and consulting company—has conducted a study on "Physician Inpatient/Outpatient Revenue" that provides benchmark data on the value of physician impact on the community. The graph below indicates incremental patient access to healthcare as measured by average net annual income generated by a general

surgeon on behalf of his/her affiliated hospital. This data demonstrates the expansive impact of each additional general surgeon.

The chart below values the access expansion of a general surgeon at $2,112,492 per year. Accordingly, ETMC's DSRIP funding request of approximately $700,000 per year (including Category 1 and 3) is targeted to be less than the value of access expansion so that the Medicare program accrues a net benefit.



208843701.3.2	***3.IT-4.4***	**Surgical site infections (SSI) rates**	
ETMC Henderson			***208843701***
Related Category 1 or 2 Projects:	***208843701.1.2***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-3 Develop and test data systems to measure surgical site infection rates **Metric:** Documentation of data capture **Data Source**: EHR, Claims, IQR/NHSN data **Process Milestone 1 Estimated Incentive Payment:** $ 59,297	**Process Milestone 2: P-2** Establish baseline rate of Surgical site infections (SSI) rates Numerator: Number of cases of SSI as designated by IQR criteria Denominator: Total number of cases **Metric:** Documentation of baseline of Surgical site infections (SSI) rates **Data Source:** EHR, Claims, IQR/NHSN data **Process Milestone 2 Estimated Incentive Payment:** $ 68,733	**Outcome Improvement Target 1: IT-4.4** Decrease Surgical site infections (SSI) rates Numerator: Number of cases of SSI as designated by IQR criteria Denominator: Total number of cases **Improvement Target:** 4% decrease in Surgical site infections (SSI) rates, calculated as (new # - baseline) /baseline **Data Source:** EHR, Claims, IQR/NHSN data **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 110,292	**Outcome Improvement Target 2: IT-4.4** Decrease Surgical site infections (SSI) rates Numerator: Number of cases of SSI as designated by IQR criteria Denominator: Total number of cases **Improvement Target:** 8% decrease in Surgical site infections (SSI) rates, calculated as (new # -baseline) /baseline **Data Source:** EHR, Claims, IQR/NHSN data **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 263,742
Year 2 Estimated Total DSRIP Funding: $59,297	Year 3 Estimated Total DSRIP Funding: $68,733	Year 4 Estimated Total DSRIP Funding: $110,292	Year 5 Estimated Total DSRIP Funding: $263,742
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$502,063***			

Outcome Measure (Improvement Target): IT-13.4 – Proportion admitted to the ICU in the last 30 days of life (NQF 0213)
Unique Outcome ID Number: 218834401.3.1
Performing Provider Name/TPI: Texas Palliative Care 218834401

Outcome Measure Description: Texas Palliative Care's goal is to reduce the proportion of their patients who died from cancer that were admitted to the ICU—post initial consult—in the last 30 days of life through expanding the Palliative Care Consult Service (PCCS) at area hospitals (218834401.2.1). Texas Palliative Care plans to engage in project planning for DY 2 by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documenting implementation plans. We will collect preliminary data in DY 3 to serve as a baseline for the proportion admitted to the ICU—post initial consult—in the last 30 days of life. Texas Palliative Care plans to decrease the percentage of their patients who died from cancer that were admitted to the ICU—post initial consult—in the last 30 days of life by 3% and 6% in demonstration years 4 and 5, respectively.

Rationale: Palliative medicine represents a different approach to patient care that focuses on the relief and prevention of suffering, and ideally can be applied in conjunction with more typical cure oriented treatment. Moreover, palliative care seeks to provide the best possible quality of life for the patient and family, regardless of prognosis. Palliative care takes an interdisciplinary approach – doctors, nurses, social workers and often chaplains – that blends with curative care for seriously ill people. Unlike traditional hospice, palliative care is targeted at people who are very sick but do not necessarily have a six-month life expectancy.

Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflects patients' desires to die at home and to not be connected to machines at the end-of-life. ICU use near the end of life may indicate a lack of discussion about advance directives. ICU care is expensive and uncomfortable, and generally not appropriate for the dying patient.

Outcome Measure Valuation: A study by Morrison et al concludes that "palliative care patients who were discharged alive had an adjusted net savings of $1,696 in direct costs per admission and $279 in direct costs per day, including significant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who died had an adjusted net savings of $4,908 in direct costs per admission and $374 in direct costs per day, including significant reductions in pharmacy, laboratory, and intensive care unit costs compared with usual care patients."

Considering the Morrison study conclusion of a direct cost savings between $1,696 and $4,908 per admission for those who receive palliative care, the chart below values 600 additional palliative care consults at $1,730,664 per year. Accordingly, the DSRIP funding request of approximately $746,000 per year (including Category 1 and 3) is targeted to be less than the savings so that the CMS program accrues a net benefit.

Expanded Palliative Care Consulting Program Estimated Annual Savings		
Discharged Alive	$1,696 @ 63%	$ 1,068
Died in Hospital	$4,908 @ 37%	$ 1,816
Weighted Avg Palliative Savings		$ 2,884
Additional Palliative Consults		600
Estimated Annual Savings		**$ 1,730,664**

(Morrison et al, "Cost savings associated with US hospital palliative care consultation programs," Arch Intern Med. 2008 Sep 8;168(16):1783-90.)

218834401.3.1	***3.IT-13.4***	***Proportion admitted to the ICU in the last 30 days of life***	
Texas Palliative Care			***218834401***
Related Category 1 or 2 Projects:	***218834401.2.1***		
Starting Point/Baseline:	*Baseline to be determined in DY3*		
Year 2	Year 3	Year 4	Year 5
Process Milestone 1: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric:** Documentation of project plans **Data Source**: Documentation of project work plans, meeting minutes, contracts, agreements, etc.	**Process Milestone 2: P-2** Establish baseline percentage of Texas Palliative Care patients who died from cancer admitted to the ICU—post initial consult—in the last 30 days of life. Numerator**:** Texas Palliative Care patients who died from cancer and were admitted to the ICU—post initial consult—in the last 30 days of life Denominator**:** Texas Palliative Care patients who died from cancer **Metric:** Documentation of baseline percentage of Texas Palliative Care patients who died from cancer admitted to the ICU—post initial consult—in the last 30 days of life. **Data Source:** EHR and claims	**Outcome Improvement Target 1: IT-13.4** Percentage of Texas Palliative Care patients who died from cancer admitted to the ICU—post initial consult—in the last 30 days of life. Numerator**:** Texas Palliative Care patients who died from cancer and were admitted to the ICU—post initial consult—in the last 30 days of life Denominator**:** Texas Palliative Care patients who died from cancer **Improvement Target:** 3% decrease in the percentage of Texas Palliative Care patients who died from cancer admitted to the ICU—post initial consult—in the last 30 days of life, calculated as (new # - baseline) /baseline **Data Source:** EHR and claims	**Outcome Improvement Target 2: IT-13.4** Percentage of Texas Palliative Care patients who died from cancer admitted to the ICU—post initial consult—in the last 30 days of life. Numerator**:** Texas Palliative Care patients who died from cancer and were admitted to the ICU—post initial consult—in the last 30 days of life Denominator**:** Texas Palliative Care patients who died from cancer **Improvement Target:** 6% decrease in the percentage of Texas Palliative Care patients who died from cancer admitted to the ICU—post initial consult—in the last 30 days of life, calculated as (new # - baseline) /baseline **Data Source:** EHR and claims
Process Milestone 1 Estimated Incentive Payment: $30,527	**Process Milestone 2 Estimated Incentive Payment:** $72,394	**Outcome Improvement Target 1 Estimated Incentive Payment:** $78,900	**Outcome Improvement Target 2 Estimated Incentive Payment:** $172,752
Year 2 Estimated Total DSRIP Funding: $30,527	Year 3 Estimated Total DSRIP Funding: $72,394	Year 4 Estimated Total DSRIP Funding: $78,900	Year 5 Estimated Total DSRIP Funding: $172,752
TOTAL EST DSRIP FUNDING FOR 4 YEARS *(add amounts of Estimated DSRIP Funding for Years 2-5):* ***$354,573***			

F. Category 4: Population-Focused Improvements (Hospitals only)

Population-focused improvements are "pay for reporting" measures reported by hospitals that demonstrate the impact of delivery system reform investments made under the demonstration. With limited exceptions, all hospital Performing Providers shall report on all Category 4 population-focused improvement measures described in Attachment I: RHP Planning Protocol and categorized in six domains:

Domain 1: Potentially Preventable Admissions (8 measures)
Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Domain 3: Potentially Preventable Complications (64 measures)
Domain 4: Patient-Centered Healthcare (2 measures)
Domain 5: Emergency Department (1 measure)
Optional Domain 6: Children and Adult Core Measures (8 measures)

Provider & TPI: ETMC Quitman 017624002

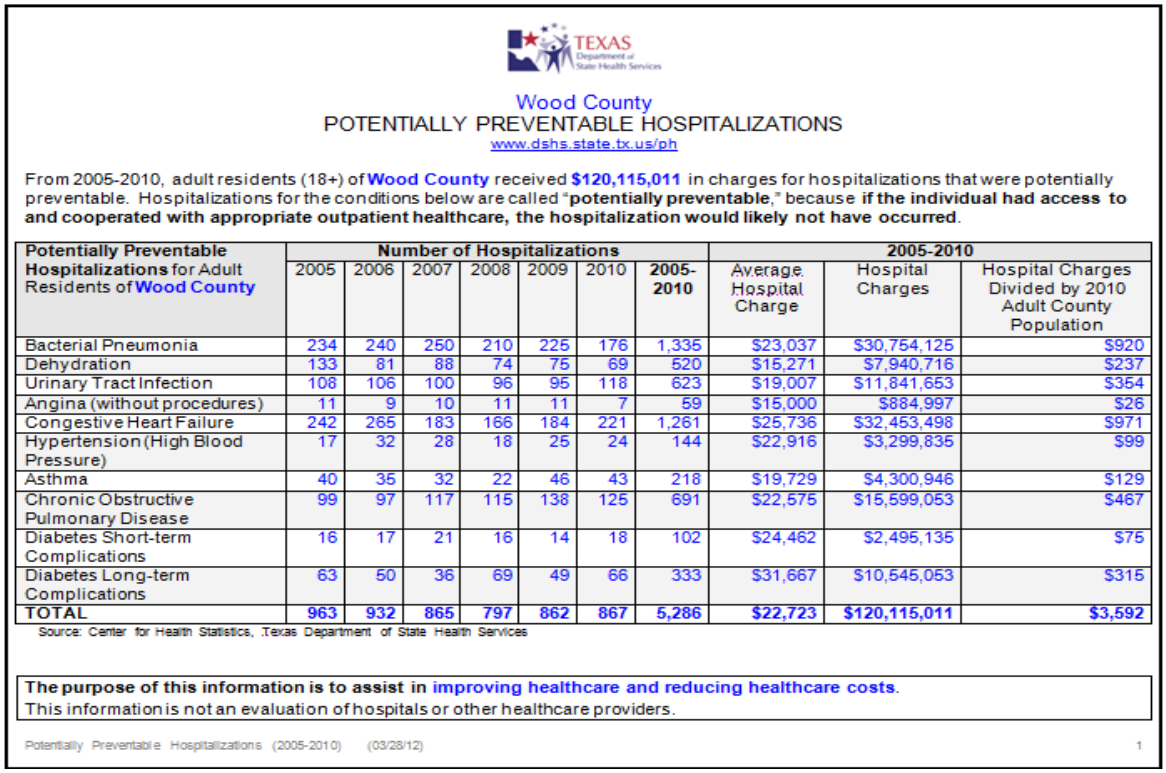
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	The ETMC Quitman clinic will begin offering additional physician staffing (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable admissions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC Quitman clinic will begin offering additional physician staffing (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable 30 day readmissions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	The ETMC Quitman clinic will begin offering additional physician staffing (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive

	Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions and prevent health complications through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	Increasing the overall quality of care and improving the health status of our target population—new ETMC primary care clinic patients—will ensure patient-centered healthcare. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable admissions while providing care in a patient-centered manner. Through additional physician recruitment, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	The ETMC Quitman clinic will begin offering additional physician staffing (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. Increasing the overall quality of care and improving the health status of our target population—new ETMC primary care clinic patients—will prevent unnecessary utilization of the ED. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will promote preventive care in the clinic setting, rather than the ED. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Wood County alone there were approximately 5,286 potentially preventable hospitalizations from 2005-2010. These patients represented more than $120M in

charges. As one of the largest providers in Wood County, ETMC Quitman's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $6M in savings over a six year period.



TEXAS Department of State Health Services

Wood County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Wood County** received **$120,115,011** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Wood County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	234	240	250	210	225	176	1,335	$23,037	$30,754,125	$920
Dehydration	133	81	88	74	75	69	520	$15,271	$7,940,716	$237
Urinary Tract Infection	108	106	100	96	95	118	623	$19,007	$11,841,653	$354
Angina (without procedures)	11	9	10	11	11	7	59	$15,000	$884,997	$26
Congestive Heart Failure	242	265	183	166	184	221	1,261	$25,736	$32,453,498	$971
Hypertension (High Blood Pressure)	17	32	28	18	25	24	144	$22,916	$3,299,835	$99
Asthma	40	35	32	22	46	43	218	$19,729	$4,300,946	$129
Chronic Obstructive Pulmonary Disease	99	97	117	115	138	125	691	$22,575	$15,599,053	$467
Diabetes Short-term Complications	16	17	21	16	14	18	102	$24,462	$2,495,135	$75
Diabetes Long-term Complications	63	50	36	69	49	66	333	$31,667	$10,545,053	$315
TOTAL	**963**	**932**	**865**	**797**	**862**	**867**	**5,286**	**$22,723**	**$120,115,011**	**$3,592**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Quitman 017624002				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$29,635	$13,740		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$13,740	$14,699	$15,977
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$13,740	$14,699	$15,977
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$14,699	$15,977
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$13,740	$14,699	$15,977
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$13,740	$14,699	$15,977
Grand Total Payments – CAT 4	**$29,635**	**$68,702**	**$73,495**	**$79,886**

Provider & TPI: ETMC Tyler 020812601

Domain Descriptions:

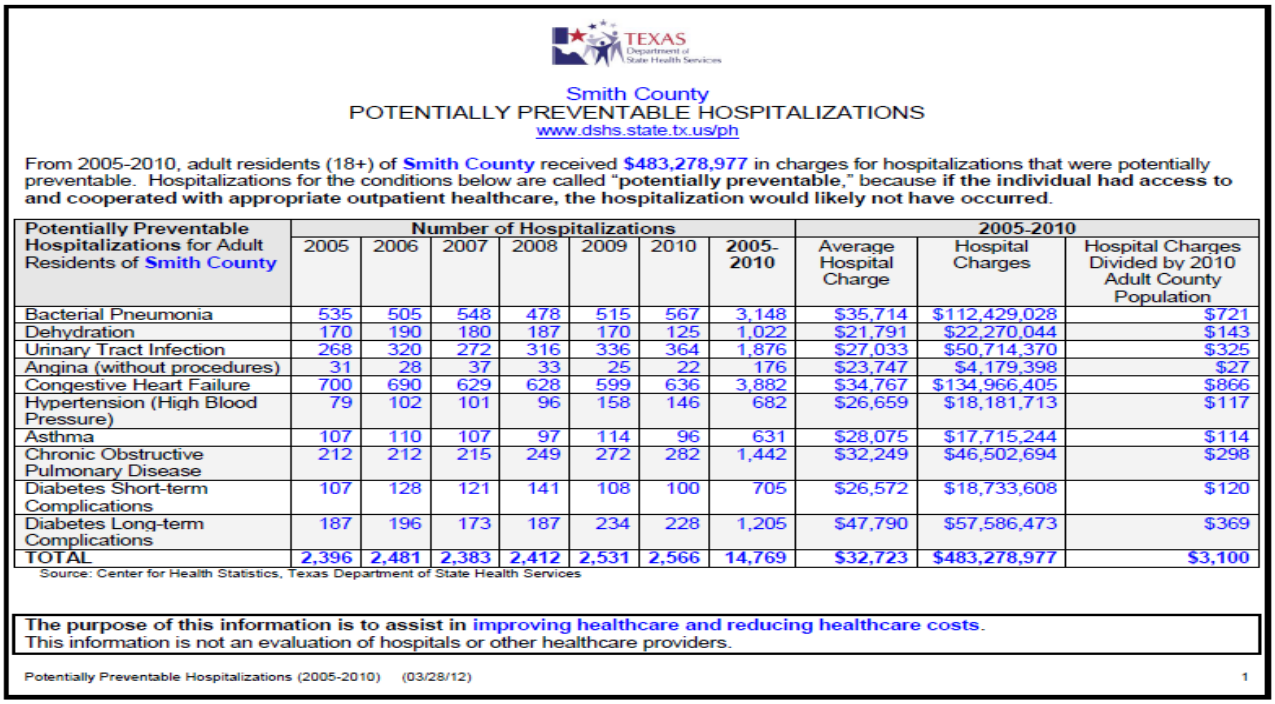
Domain	Description
Potentially Preventable Admissions	ETMC Tyler plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Hiring an endocrinologist (1.9.2) provides expansion of services for referred diabetic patients in the ED. The ED triage protocol will create the ability to refer non-urgent patients to the more efficient outpatient clinic setting. Managing the care of diabetic patients will improve health outcomes, decrease the cost of care, and decrease potentially preventable admissions. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (1.9.2) provides expansion of services for behavioral health patients and prevents future admissions. Expanded cardiology coverage (1.9.2) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will lower the cost of cardiac care by decreasing potentially preventable admissions. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	Expanded cardiology coverage (1.9.2) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing 30 day readmissions and lowering the cost of cardiac care. Moreover, expanding care transitions programs (2.12) by establishing new discharge protocols and implementing Project RED for cardiac patients will also improve outcomes and decrease 30 day readmissions. Furthermore, hiring an endocrinologist (1.9.2) provides expansion of services for diabetic patients and creates a follow-up option for patients discharged from a diabetes related inpatient stay. Managing the care of diabetic patients will improve health outcomes, decrease the cost of care, and decrease potentially preventable 30 day readmissions. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (1.9.2) provides expansion of services for behavioral health patients. Expanded outpatient and partial hospitalization services will create appropriate follow-up care (IT-1.18) for behavioral health patients and prevent 30 day readmissions.

	Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	Hiring an endocrinologist (1.9.2) provides expansion of services for diabetic patients, provides preventive care management for their chronic condition, and creates a follow-up option for patients discharged from a diabetes related inpatient stay. Managing the care of diabetic patients will improve health outcomes, decrease the cost of care, and decrease potentially preventable complications from diabetes. In addition, expanded cardiology coverage (1.9.2) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. Managing the care of CHF and other cardiac patients will improve health outcomes while decreasing potentially preventable complications and lowering the cost of cardiac care. Decreasing complications from CHF will come through management of medications and blood pressure and lessen the need for inpatient services. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for diabetes and CHF. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	Redesigning to improve the patient experience (2.4) unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs. Patient-centered healthcare is proven to lead to improved outcomes and decreased cost. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Tyler plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. In addition, expanding behavioral health outpatient and partial hospitalization services with a psychiatrist (1.9.2) provides expansion of services for referred behavioral health patients in the ED. The ED triage protocol will create the ability to refer non-urgent, behavioral health patients to the more efficient outpatient and partial hospitalization services. Expanded behavioral health services will also prevent unnecessary mental health utilization of the ED. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed

	availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation:

As shown in the chart below, The Texas Department of State Health Services suggests that in Smith County alone there were approximately 14,769 potentially preventable hospitalizations from 2005-2010. These patients represented more than $483M in charges. As one of the largest providers in Smith County, ETMC Tyler's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $24M in savings over a six year period.



TEXAS Department of State Health Services

Smith County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Smith County** received **$483,278,977** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of Smith County	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	2005-2010	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	535	505	548	478	515	567	3,148	$35,714	$112,429,028	$721
Dehydration	170	190	180	187	170	125	1,022	$21,791	$22,270,044	$143
Urinary Tract Infection	268	320	272	316	336	364	1,876	$27,033	$50,714,370	$325
Angina (without procedures)	31	28	37	33	25	22	176	$23,747	$4,179,398	$27
Congestive Heart Failure	700	690	629	628	599	636	3,882	$34,767	$134,966,405	$866
Hypertension (High Blood Pressure)	79	102	101	96	158	146	682	$26,659	$18,181,713	$117
Asthma	107	110	107	97	114	96	631	$28,075	$17,715,244	$114
Chronic Obstructive Pulmonary Disease	212	212	215	249	272	282	1,442	$32,249	$46,502,694	$298
Diabetes Short-term Complications	107	128	121	141	108	100	705	$26,572	$18,733,608	$120
Diabetes Long-term Complications	187	196	173	187	234	228	1,205	$47,790	$57,586,473	$369
TOTAL	2,396	2,481	2,383	2,412	2,531	2,566	14,769	$32,723	$483,278,977	$3,100

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Tyler 020812601				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$372,730	$172,817		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$172,817	$184,874	$200,950
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$172,817	$184,874	$200,950
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$184,874	$200,950
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$172,817	$184,874	$200,950
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$172,817	$184,874	$200,950
Grand Total Payments – CAT 4	**$372,730**	**$864,084**	**$924,369**	**$1,004,749**

Provider & TPI: Good Shepherd Medical Center Longview 094095902

Domain Descriptions:
A care navigation program will lead to improvement in all Domains except optional Domain 6.
The expected improvement in Domain 1, preventable admissions and Domain 2, preventable readmissions will be a 5% reduction in preventable admissions as well as preventable readmissions over baseline by providing early intervention and follow up through improved outpatient services with this high risk population.
In Domain 3: Preventable complications the improvement will be significant in that the early intervention will allow for treatment in early stages of disease. With chronic conditions stable at the time of admission, the risk for complications is significantly reduced. The expected improvement is 3% over baseline.
Domain 4: Patient Satisfaction will be improved with shorter hospital stays treating only acute conditions. Patients will be well informed regarding their conditions, with a clear understanding of expectations for the hospital stay and an established course post hospitalization. Reduced anxiety and established relationship with the healthcare community will lead to improved satisfaction scores. The expected improvement is 1% over baseline.
Domain 5: Emergency Department will be impacted as the Care Navigation program implementation in this patient population having and established relationship with a mental health provider thus facilitating movement within the system and timely requests for transfer.
Domain 6: This domain will not be impacted as the target population for this program is mental health patients, not the population for the adult and pediatric core measures which are obstetrical and medical pediatric.

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

Valuation of the project included cost avoidance with reduced Emergency Department costs for extended stay and repeat admissions of individuals that are non-medical in nature, but require a "safe environment". Similarly, an expected reduction of admissions and repeat admissions into the hospital through the ED is expected with an increased availability for the hospitals to treat non-psychiatric patients thereby generating revenue by admissions that are in the right place at the right time. An expected reduction of admissions to the state hospital will be achieved through wrap around services and keeping individuals in the community appropriately and preventing loss of work productivity for long periods of absence from the community. Transportation costs for the counties will be reduced and will free law enforcement to return to work "on the streets" for safety issues. Valuing was determined using the following information related to cost savings related to use of navigators. Calculating cost reductions is complicated, but local studies have demonstrated significant savings. Among diabetes patients in Baltimore, intervention by a community health worker resulted in savings of $2,245 per patient, while costs for asthma patients in Hawaii were cut from $735 to

$181 through reduced emergency room visits and improved quality of life. In Denver, case management by community health workers saved $2.28 for every $1 spent on the program.

Category 4: Population-Focused Measures *[Good Shepherd Medical Center - Longview/094095902]*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$37,938	$74,375		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2				
Domain 1 - Estimated Maximum Incentive Amount		$14,875	$12,396	$12,396
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		$14,875	$12,396	$12,396
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				
Domain 3 - Estimated Maximum Incentive Amount			$12,396	$12,396
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 4 - Estimated Maximum Incentive Amount		$14,875	$12,396	$12,396
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2				

Domain 5 - Estimated Maximum Incentive Amount		$14,875	$12,396	$12,396
<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Frequency of ongoing prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Timeliness of prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean rate for low-risk first birth women				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Percent of live births weighing <2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric central-line associated bloodstream infection (CLASBI) rates				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective delivery prior to 39 weeks completed gestation				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Appropriate use of antenatal steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Postpartum Care Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$14,875	$12,396	$12,396

Grand Total Payments Across Category 4	$37,938	$74,375	$74,375	$74,375

Provider & TPI: Mother Frances Hospital/094108002

Mother Frances Hospital will report on five (5) of the six (6) domain options. MFH will not report on Domain 6. We will not be able to report on D-6 at this time because of the lack of significant data retrieval.

Category 4, while focused on reporting, clearly gives us an opportunity to see the outcomes of these projects in a very visible manner. Mother Frances Hospital is already on the journey of quality improvement across the system and has taken the imitative to move quickly on the programs and outcome measures once the design of the projects was released. To that point, workgroups, including providers, staff, community health care providers, and others, are working together to address and understand the opportunity to impact quality of care and thus the cost drivers of health care.

TMF believes the selection of the projects and outcomes measures tie to all of the domains which will be reported (1-5) and that the goal is to impact the issues in a positive manner over the five years of this program. It is with a study of the evidence based literature and best practices that the projects are being implemented, outcomes evaluated and our reporting processes will all be tied together.
As part of this document, there is a brief vision of the issues and key data information as well as a brief targeted piece on the outcomes and projects as they relate to Category 4.

Potentially Preventable Admissions (PPAs)
"Hospital inpatient care is the most expensive type of health care. Reducing preventable hospitalizations are one way to lower America's $2.2 trillion medical bill," according to an April 29, 2009, AHRQ news article-. Continuing the article stated, "American hospitals spend nearly $31 billion10 percent of their total patient care budget-2006 on more than 4 million patients that could possibly have been prevented with timely and effective ambulatory care."
Reports in both 2006 and 2008 by the AHRQ (1 and 2) show that approximately one of every ten hospital admissions is potentially preventable. In the 2008 report (2) the South had the highest rate of potentially preventable admissions (PPAs). Acute illness accounts for 3.9% of these admissions, and chronic conditions account for 6.2% (2). Studies show that a large portion of the potentially preventable hospitalizations involved the elderly. One in five admissions of Medicare patients was potentially preventable, and overall, Medicare patients account for roughly two-thirds of the money spent for PPAs.
A Med PAC analysis of the data in 2009 showed that for Medicaid patients, 10% of their emergency room visits were non-urgent and 28% occurred during normal office hours (3). Reducing PPAs is an outcome quality measure heavily influenced by access to care – for preventive and screenings - preferably in the most cost efficient setting. It also requires appropriate access to specialists and education of the patients and their caregivers so they can actively participate in their health care. Although not all potentially preventable readmissions can be avoided, a decrease in the rate indicates health care delivery improvement.
Mother Frances Hospital-Tyler will measure and report on the following PPAs: 1) congestive heart failure; 2) diabetes; 3) behavioral health and substance abuse; 4) chronic obstructive pulmonary

disease and asthma in adult patients; 5) hypertension; 6) pediatric asthma; 7) bacterial pneumonia immunization; and 8) influenza immunization administration.
The cumulative effect of the projects will be to reduce the PPAs. The goal is to have a sustained reduction in the number of potentially preventable admissions. Expanding primary care capacity is anticipated to reduce preventable admissions by managing acute illnesses at an early stage and making appropriate referrals to specialty care when needed. By expanding providers, restructuring clinic hours, and decreasing the amount of time for patients to obtain appointments for both primary care and specialists, in a setting that focuses on patient satisfaction and ease of access, we anticipate a reduction in potentially preventable admissions. Having pediatric specialist available via telemedicine also has a huge potential to prevent admissions when care can be given in a more effective and efficient manner.

Potentially Preventable Readmissions (30 Day readmission Rates)
Hospital readmissions are increasingly viewed as indicative of quality of care issues, ranging from complications during the hospital stay or immediately afterward, incomplete treatment of the underlying medical problem during the hospitalization, or poor or no outpatient care. Readmissions are also costly; thereby fueling the interest in linking payment to quality of care, especially when these readmissions might have been avoided," from Public Law section 2807-c (35) (b) (v) effective date of 2/23/11. Although some readmissions cannot be avoided due to progression of disease or expected worsening of chronic conditions, studies have demonstrated a wide range of 30 day readmissions (12-76%) which implies a direct relationship with the quality of care during the hospitalization and transition of care at discharge to home or another facility. (4, 5). Multiple randomized trials have showed that readmission rates both overall or for specific disease states can be reduced 20-40 percent. (6,7)
Mother Frances Hospital-Tyler will measure and report on the following potentially preventable readmissions, 30 day readmission rates: 1) congestive heart failure; 2) diabetes; 3) behavioral health and substance abuse; 4) chronic obstructive pulmonary disease; 5) stroke; 6) pediatric asthma; and 7) all cause. The previously proposed projects, in conjunction with ongoing initiatives such as the BOOST program from the Society of Hospital Medicine established in 2011, will reduce readmissions while providing improved patient outcomes.
Access to care and patient navigators as well as the care transition teams targeting patient discharge to assisting with care issues, are critical to reducing potentially preventable readmissions. Only by having a strong and open access for care for both primary and specialty care will you see improvement in the outpatient setting to support the efforts being done to redirect patients to the outpatient settings. Having quality specialty providers that support patients and improve care and care plans for patients while they are still in the hospital begins the programs to keep patients from returning even earlier and at a time when family members are able to receive support also. Those efforts will be part of the cost saving programs that will be measurable and accountable with new financial cost accounting programs.

Potentially Preventable Complications (PPC's)
The 3 M company has generated a list of 64 conditions consider to be potential preventable complications of inpatient treatment of procedures. One study found that in California and Maryland in one year that 9.39% and 9.63% of complications were avoidable respectively. (8). Many

complications are not linked to medical errors or defined problems in quality and safety (9); however, specific complications have been shown to be amenable to intervention. For examples, rates of central line associated bloodstream infection (PPC 54) decreased by 66% in one study with introduction of a checklist and bundling of services (10). The reduction of complications results in improvement of both morbidity and mortality for patients, decreased length of stay and cost and a higher degree of patient satisfaction.

"Complications do not necessarily represent medical errors, since they are not always preventable even with optimal care. In deciding which complications to classify as potentially preventable, the physician panel developed the following conceptual guide: If a hospital or other health care facility was to have a statistically significant, higher rate of a particular complication than comparable hospitals, reasonable clinicians would suggest further investigation for possible problems, " according to the Health Care Financing Review , spring 2006.

Trinity Mother Frances-Tyler will measure and report on the 64 potentially preventable complications as defined by 3M. Reducing potentially preventable complications is a priority for hospitals. Working with the team of multidisciplinary health care providers with care transition teams and patient navigators it is anticipated to have a high potential for positively affecting PPC's. Setting quality initiatives as a high priority is a key factor in the selection of projects for the waiver and a recognition that high quality has a direct impact on lowering the cost of care. Consequently, it makes both good investments financially and for the health of the patients to invest in primary and specialty care. Access for preventative and screenings exams allows for early detection of potential problems and development of a care management plan for any issue including long term illnesses. Care transition teams and navigators support and direct much of the care that reduces potential complications both as inpatients and outpatients.

Patient Centered Healthcare

Sections 3011 and 10302 of the Affordable Care Act amended Section 399HH of the Public Health Service Act to develop an improved plan for the delivery of health care services including population health and outcomes. In March, 2011, the National Strategy for Quality Improvement in Health Care was published (11). One key provision was an emphasis on the patient and caregiver experience. Engagement of patients and caregivers in decision making based on their preferences and needs results in improved patient outcomes and self-management (12). Improved discharge communication with regard to medication management has been shown to decreased readmissions (6).

Mother Frances Hospital-Tyler will measure and report on the following on patient satisfaction (care from doctors and nurses, the hospital environment and when the patient left the hospital) and medication management (receipt of a comprehensive written medication reconciliation at discharge including which medications should not be taken and any allergic or adverse medication reactions that occurred during the stay).

Patient satisfaction is a part of several of the projects to be developed and implemented in this waiver program. It is one of the corner stone beliefs that providing high quality of care and being transparent about all aspect of care, investing in providers and staff that will work together as an integrated health care team for both inpatient and outpatient services will result in better outcomes because of the improved access and support. The next step is for patient satisfaction scores to improve and both the providers and the patients are in a system whereby they have a strong bond of trust and communication. Supported by an electronic health records system like EPIC that crosses

both areas of care adds an additional layer of care and trust and improvement for patients. Having healthier patients then results in lowering the cost of care for all payers and the patients.

Emergency Department

Delayed emergency department throughput is problematic for a number of reasons. Delays in reaching an inpatient bed may delay administration of some medications and provide suboptimal nursing care. Inpatients in the emergency department prevent other patients in waiting and triage area from receiving timely and focused care as well. (13, 14)

Mother Frances Hospital-Tyler will measure and report on the time from the decision to admit the patient to the time that patient departs the emergency room.

To maximize the potential for improvement will require opening new and expanding current access points of care is the best and most immediate and long term way to impact the emergency department. Finally, improving the ability to developing the ability to analyze the cost of care will be used across the board in expanding the lessons learned from this project.

The emergency room is where all too many pediatric patients are seen. The telemedicine project expands the opportunity to determine what the right place and right time for specialty care for pediatric is.

In conclusion all the projects proposed by Mother Frances Hospital support the Category 4 domains and will impact the outcomes over the period of this grant. Just as important or perhaps even more importantly, all of the projects submitted for approval at sustainable after the grant period and will continue to support further impact on this domains.

The focus of Category I projects is infrastructure development that lays the foundation for delivery system transformation through investments in technology, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Expanding primary care capacity is anticipated to reduce preventable admissions by managing acute illnesses at an early stage and making appropriate referrals to specialty care when needed. By expanding providers, restructuring clinic hours, and decreasing the amount of time for patients to obtain appointments for both primary care and specialists, in a setting that focuses on patient satisfaction and ease of access, we anticipate a reduction in potentially preventable admissions.

Critical to the process is our ability, through expanding specialists and primary care, for those referrals to be with a NCQA Level III Medical Home within Trinity Clinic and the use of the new integrated electronic medical record system for all hospitals and clinics within the system. Thus, providing real time information for all providers to ensure the care is being given at the right time and in the right place, hopefully reducing 30-day readmissions.

Program innovation and redesign is the focus of Category II projects which includes the redesign for cost containment. Simply stated, the goal of this project is to implement the processes and systems that will lower the cost of care while maintaining and improving high quality outcomes. this includes all the elements of Category 4.

Finally, improving the ability to developing the ability to analyze the cost of care will be used across the board in expanding the lessons learned from this project.

Achieving quality improvement outcomes is also expected to impact all the domains. Patient satisfaction will support the expanded access and use of third available appointments to make it easier for patients to see their provider knowing they have access and support in a medical home model clinic. Addressing the community need of a lack of urgent care access, CN.1, and utilization of

the ED for non-emergent visits, CN.5) are factors influencing the delay in ED through put. Improving that through put, improving patient satisfaction quality measures, and having improved primary care access are key elements in the valuation of this project.
Other elements tied to the costs are new software and implementing electronic systems to capture, measure, and report required data. Appropriate staffing for clinical analysts and reporting of quality data will also be needed.

Domain Valuation
The valuation for measuring potentially preventable admission is first focused on meeting a community need as identified in the regional planning community needs assessment as CN.4. Other elements tied to the costs are new software and implementing electronic systems to capture, measure, and report required data. Also appropriate staffing for clinical analysts will be needed and reporting of quality data. MFH has experienced cost reductions and improved patient satisfaction when the quality of an element is improved. All of these are key to determining the valuation of potentially preventable admissions.
The valuation for measuring potentially preventable readmissions, 30-day readmissions is influenced in meeting a community need as identified in the regional planning community needs assessment as CN.3 which shows a high rate of people with chronic conditions that frequently lead to hospital readmission. Other elements tied to the costs are new software and implementing electronic systems to capture, measure, and report required data. Appropriate staffing for clinical analysts and reporting of quality data will also be needed
By enhancing performance improvement and reporting capacity we expect to consistently reduce the potentially preventable readmissions, 30-day readmission rate.
MFH has experienced improved cost reductions and patient satisfaction when the quality of an element is improved. All of these are key to determining the valuation of potentially preventable readmission, 30-day readmissions.
The valuation for measuring potentially preventable complications is important for its influence on other areas like readmission rates. To improve on the PPC's should impact the outcomes for other measures such as patient satisfaction also. By enhancing performance improvement and reporting capacity we expect to consistently reduce the potentially preventable complication rates.
Elements tied to the costs are new software and implementing electronic systems to capture, measure, and report required data. Appropriate staffing for clinical analysts and reporting of quality data will also be needed.
The valuation for measuring patient centered healthcare is influenced in meeting a community need as identified in the regional planning community needs assessment as CN.6 which shows that an effective healthcare delivery is a regional focus. Other elements tied to the costs are patient surveys, new software and implementing electronic systems to capture, measure, and report required data. Appropriate staffing for clinical analysts and reporting of quality data will also be needed

Sources:

1. Jiang, H. et al. Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2006. Health Care and Cost and Utilization Project. AHRQ Statistical Brief #72

2. Stranges, E. and Stocks, C. Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2008. Health Care and Cost and Utilization Project. AHRQ Statistical Brief #99.
3. Medicare Payment Advisory Committee (MedPAC). Report to Congress on 2009 National Hospital Ambulatory Discharge Survey
4. Benbasset, J. and Taragin, M. Hospital readmissions as a measure of quality of health care: advantages and limitations. Arch Inter Med 2000; 160(8):1074-81.
5. MedPAC . Report to the Congress promoting greater efficiency in Medicare. 2007.
6. Coleman, E. et al. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriar Soc. 2004: 52(11):1817-25.

   Jack, B. et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Intern Med 2009; 150(3):178-87.
7. Fuller, R. et all. Estimating the costs of potentially preventable hospital acquired complications. Healthcare Financing Reviews. 30:4. 2009.
8. Averill, et al. Hospital complications: linking payment reduction to preventability. Jt Comm J Qual Patient Saf 35(5): 283-285.
9. Provonost, et al. The wisdom and justice of not paying for “preventable complications.” JAMA 299(18):2197-2199.
10. http://www.healthcare.gove/law/resources/reports/nationalqualitystrategy032011.pdf
11. Balik, B. et al. Achieving an exceptional patient and family experience of inpatient hospital care. IHI Innovation Series white paper. Cambridge, MA. 2011.
12. Massingale, L. Emergency department throughput: recognizing and addressing 5 common inhibitors. HealthLeaders News. 12/7/2007.
13. National Public Health and Hospital Institute (NPHHI). Strategies to improve emergency department overcrowdings: data from NPHHI. Data Brief April, 2011.
14. Strong Start Initiative. http://www.innovation.cms.gove/intiatives/strong-start.

Category 4: Population-Focused Measures Mother Frances Hospital/094108002				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$650,879	$302,741		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		Apr. 1 – Sept. 30	Apr. 1 – Sept. 30	Apr. 1 – Sept. 30
Domain 1 - Estimated Maximum Incentive Amount		$302,741	$324,722	$353,322
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		Apr. 1 – Sept. 30	Apr. 1 – Sept. 30	Apr. 1 – Sept. 30
Domain 2 - Estimated Maximum Incentive Amount		$302741	$324,722	$353,322
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			Apr. 1 – Sept. 30	Apr. 1 – Sept. 30
Domain 3 - Estimated Maximum Incentive Amount			$324,722	$353,322
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		Jan. 1 – Dec. 31	Jan. 1 – Dec. 31	Jan. 1 – Dec. 31
Planned Reporting Period: 1 or 2		Apr. 1 – Sept. 30	Apr. 1 – Sept. 30	Apr. 1 – Sept. 30
Medication Management				
Measurement period for report		Jan. 1 – Dec. 31	Jan. 1 – Dec. 31	Jan. 1 – Dec. 31
Planned Reporting Period: 1 or 2		Apr. 1 – Sept. 30	Apr. 1 – Sept. 30	Apr. 1 – Sept. 30
Domain 4 - Estimated Maximum Incentive Amount		$302,741	$324,722	$353,322
Domain 5: Emergency Department				
Measurement period for report		Jan. 1 – Dec. 31	Jan. 1 – Dec. 31	Jan. 1 – Dec. 31
Planned Reporting Period: 1 or 2		Apr. 1 – Sept. 30	Apr. 1 – Sept. 30	Apr. 1 – Sept. 30

Domain 5 - Estimated Maximum Incentive Amount		$302,741	$324,722	$353,322.
<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$NA	$NA	$NA
Grand Total Payments Across Category 4	$650,879	$1,513,705	$1,623,610	$1,766,610

Provider & TPI: ETMC Carthage 094127002

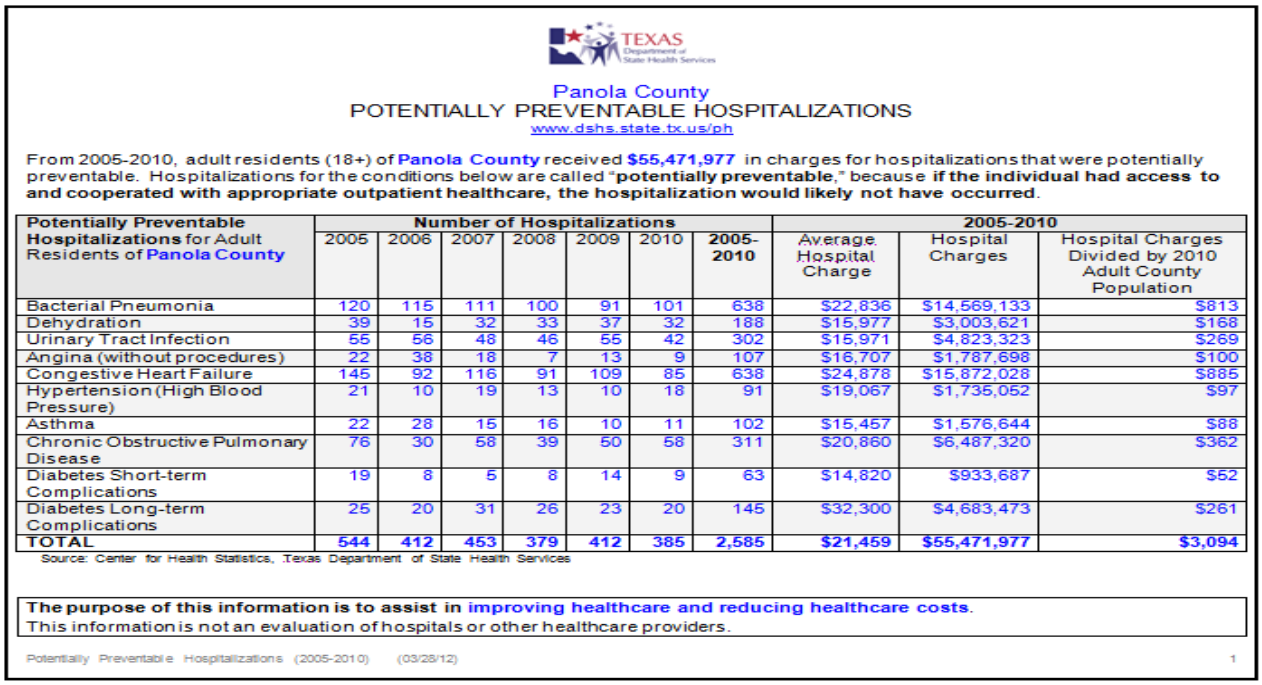
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable readmissions due to expanded primary care access and improved preventive care.

	Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will provide a patient-centered experience due to expanded primary care access and improved preventive care. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Carthage plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality

	and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Panola County alone there were approximately 2,585 potentially preventable hospitalizations from 2005-2010. These patients represented more than $55M in charges. As one of the largest providers in Panola County, ETMC Carthage's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $2.75M in savings over a six year period.



TEXAS Department of State Health Services

Panola County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Panola County** received **$55,471,977** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Panola County**	**Number of Hospitalizations**						**2005-2010**	**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	120	115	111	100	91	101	638	$22,836	$14,569,133	$813
Dehydration	39	15	32	33	37	32	188	$15,977	$3,003,621	$168
Urinary Tract Infection	55	56	48	46	55	42	302	$15,971	$4,823,323	$269
Angina (without procedures)	22	38	18	7	13	9	107	$16,707	$1,787,698	$100
Congestive Heart Failure	145	92	116	91	109	85	638	$24,878	$15,872,028	$885
Hypertension (High Blood Pressure)	21	10	19	13	10	18	91	$19,067	$1,735,052	$97
Asthma	22	28	15	16	10	11	102	$15,457	$1,576,644	$88
Chronic Obstructive Pulmonary Disease	76	30	58	39	50	58	311	$20,860	$6,487,320	$362
Diabetes Short-term Complications	19	8	5	8	14	9	63	$14,820	$933,687	$52
Diabetes Long-term Complications	25	20	31	26	23	20	145	$32,300	$4,683,473	$261
TOTAL	**544**	**412**	**453**	**379**	**412**	**385**	**2,585**	**$21,459**	**$55,471,977**	**$3,094**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Carthage 094127002				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$39,206	$18,178		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$18,178	$19,446	$21,137
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$18,178	$19,446	$21,137
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$19,446	$21,137
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$18,178	$19,446	$21,137
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$18,178	$19,446	$21,137
Grand Total Payments – CAT 4	**$39,206**	**$90,889**	**$97,230**	**$105,685**

Provider & TPI: ETMC Fairfield 094190802

Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable readmissions due to expanded primary care access and improved

	preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will provide a patient-centered experience due to expanded primary care access and improved preventive care. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Fairfield plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the

	more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Freestone County alone there were approximately 2,460 potentially preventable hospitalizations from 2005-2010. These patients represented more than $49M in charges. As one of the largest providers in Freestone County, ETMC Fairfield's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at almost $2.5M in savings over a six year period.

TEXAS Department of State Health Services

Freestone County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Freestone County** received **$49,283,210** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Freestone County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	135	121	153	117	102	86	714	$21,303	$15,210,056	$1,002
Dehydration	22	27	20	37	24	16	146	$13,563	$1,980,203	$130
Urinary Tract Infection	67	42	38	46	54	57	304	$16,751	$5,092,281	$335
Angina (without procedures)	15	9	8	10	7	7	56	$14,008	$784,450	$52
Congestive Heart Failure	112	146	138	118	100	77	691	$20,654	$14,271,771	$940
Hypertension (High Blood Pressure)	10	11	0	13	10	21	65	$16,359	$1,063,334	$70
Asthma	12	10	6	15	29	25	97	$17,875	$1,733,874	$114
Chronic Obstructive Pulmonary Disease	53	40	36	36	52	35	252	$18,645	$4,698,447	$309
Diabetes Short-term Complications	5	8	5	20	11	10	59	$22,483	$1,326,499	$87
Diabetes Long-term Complications	16	12	14	9	17	8	76	$41,083	$3,122,295	$206
TOTAL	**447**	**426**	**418**	**421**	**406**	**342**	**2,460**	**$20,034**	**$49,283,210**	**$3,245**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
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Headache	2,078	189	1,219	645	84
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Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Fairfield 094190802				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$17,286	$8,014		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$8,014	$8,574	$9,319
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$8,014	$8,574	$9,319
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$8,574	$9,319
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$8,014	$8,574	$9,319
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$8,014	$8,574	$9,319
Grand Total Payments – CAT 4	**$17,286**	**$40,072**	**$42,868**	**$46,596**

Provider & TPI: ETMC Trinity 121817401

Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable readmissions due to expanded primary care access and improved preventive care.

	Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will provide a patient-centered experience due to expanded primary care access and improved preventive care. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Trinity plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality and

	decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Trinity County alone there were approximately 2,511 potentially preventable hospitalizations from 2005-2010. These patients represented more than $66M in charges. As one of the largest providers in Trinity County, ETMC Trinity's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $3M in savings over a six year period.

TEXAS Department of State Health Services

Trinity County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Trinity County** received **$66,542,171** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Trinity County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	101	75	96	88	80	75	515	$31,844	$16,399,594	$1,421
Dehydration	36	11	18	18	21	24	128	$14,900	$1,907,227	$165
Urinary Tract Infection	45	46	59	62	66	60	338	$21,944	$7,417,161	$643
Angina (without procedures)	8	8	0	0	7	6	0	$0	$0	$0
Congestive Heart Failure	129	96	101	83	93	113	615	$26,892	$16,538,834	$1,433
Hypertension (High Blood Pressure)	6	7	15	14	17	13	72	$21,736	$1,564,974	$136
Asthma	44	33	39	24	42	25	207	$21,540	$4,458,816	$386
Chronic Obstructive Pulmonary Disease	74	75	75	86	91	69	470	$26,302	$12,361,908	$1,071
Diabetes Short-term Complications	0	10	6	11	7	11	45	$24,557	$1,105,048	$96
Diabetes Long-term Complications	22	20	21	16	17	25	121	$39,575	$4,788,609	$415
TOTAL	**465**	**381**	**430**	**402**	**441**	**421**	**2,511**	**$26,500**	**$66,542,171**	**$5,764**

Source: Center for Health Statistics, Texas Department of State Health Services
The number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS.
Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Trinity 121817401				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$40,207	$18,642		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$18,642	$19,943	$21,677
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$18,642	$19,943	$21,677
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$19,943	$21,677
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$18,642	$19,943	$21,677
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$18,642	$19,943	$21,677
Grand Total Payments – CAT 4	**$40,207**	**$93,210**	**$99,713**	**$108,383**

Provider & TPI: ETMC Jacksonville 130612806

Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable readmissions due to expanded primary care access and improved

	preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will provide a patient-centered experience due to expanded primary care access and improved preventive care. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Jacksonville plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent

	patients to the more appropriate outpatient setting where they can experience improved quality and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Cherokee County alone there were approximately 4,571 potentially preventable hospitalizations from 2005-2010. These patients represented more than $126M in charges. As one of the largest providers in Cherokee County, ETMC Jacksonville's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $6M in savings over a six year period.

TEXAS Department of State Health Services

Cherokee County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Cherokee County** received **$126,956,599** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Cherokee County**	Number of Hospitalizations						2005-2010			
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	170	171	175	153	178	192	1,039	$31,948	$33,193,984	$881
Dehydration	63	72	66	70	82	58	411	$18,106	$7,441,384	$198
Urinary Tract Infection	78	87	72	105	116	116	574	$23,577	$13,533,071	$359
Angina (without procedures)	17	10	14	8	14	6	69	$18,911	$1,304,886	$35
Congestive Heart Failure	189	170	180	167	159	193	1,058	$30,233	$31,986,251	$849
Hypertension (High Blood Pressure)	19	27	25	24	27	35	157	$17,468	$2,742,426	$73
Asthma	43	32	38	42	48	59	262	$25,143	$6,587,401	$175
Chronic Obstructive Pulmonary Disease	93	83	88	91	100	104	559	$27,174	$15,190,129	$403
Diabetes Short-term Complications	27	15	16	15	22	25	120	$20,529	$2,463,494	$65
Diabetes Long-term Complications	37	68	41	42	60	74	322	$38,862	$12,513,574	$332
TOTAL	**736**	**735**	**715**	**717**	**806**	**862**	**4,571**	**$27,774**	**$126,956,599**	**$3,370**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Jacksonville 130612806				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$55,332	$25,655		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$25,655	$27,445	$29,831
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$25,655	$27,445	$29,831
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$27,445	$29,831
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$25,655	$27,445	$29,831
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$25,655	$27,445	$29,831
Grand Total Payments – CAT 4	**$55,332**	**$128,274**	**$137,223**	**$149,155**

Provider & TPI: ETMC Clarksville 130862905

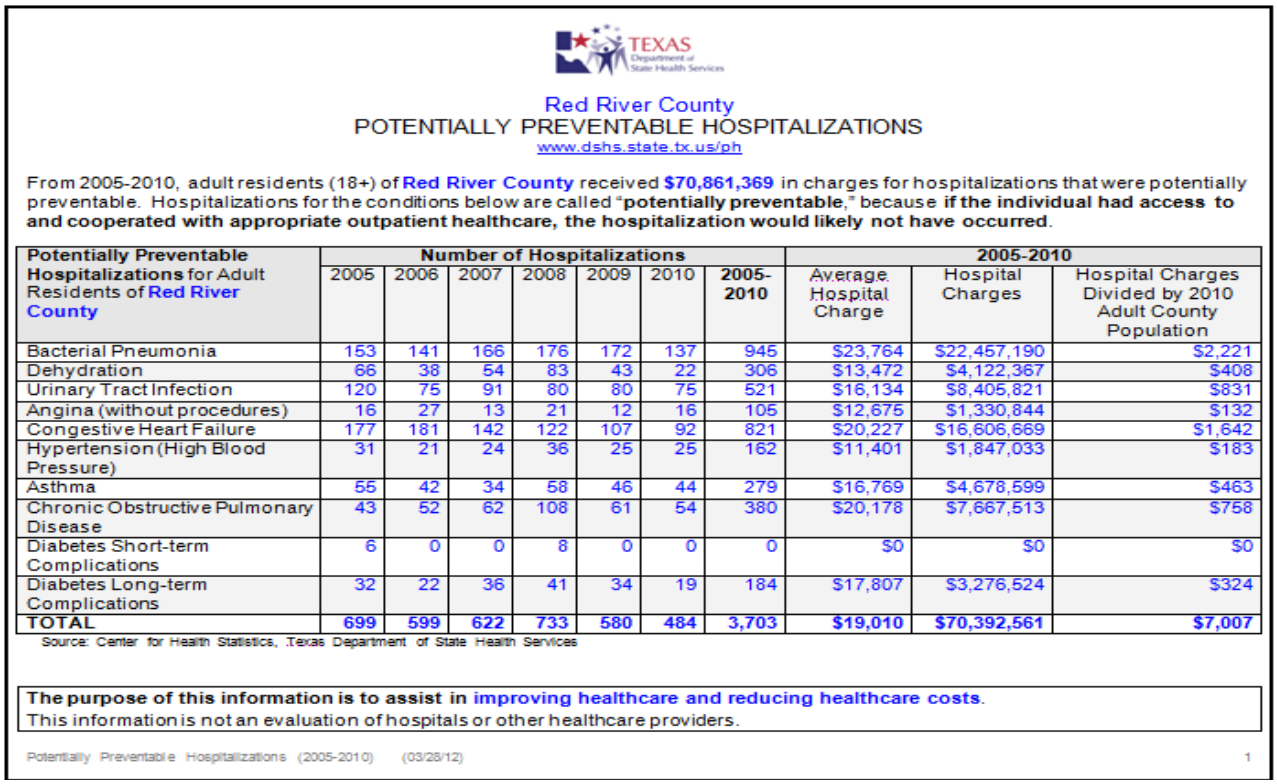
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable readmissions due to expanded primary care access and improved preventive care.

	Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will provide a patient-centered experience due to expanded primary care access and improved preventive care. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Clarksville plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality

	and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Red River County alone there were approximately 3,703 potentially preventable hospitalizations from 2005-2010. These patients represented more than $70M in charges. As one of the largest providers in Red River County, ETMC Clarksville's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $3.5M in savings over a six year period.



TEXAS Department of State Health Services

Red River County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Red River County** received **$70,861,369** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Red River County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	153	141	166	176	172	137	945	$23,764	$22,457,190	$2,221
Dehydration	66	38	54	83	43	22	306	$13,472	$4,122,367	$408
Urinary Tract Infection	120	75	91	80	80	75	521	$16,134	$8,405,821	$831
Angina (without procedures)	16	27	13	21	12	16	105	$12,675	$1,330,844	$132
Congestive Heart Failure	177	181	142	122	107	92	821	$20,227	$16,606,669	$1,642
Hypertension (High Blood Pressure)	31	21	24	36	25	25	162	$11,401	$1,847,033	$183
Asthma	55	42	34	58	46	44	279	$16,769	$4,678,599	$463
Chronic Obstructive Pulmonary Disease	43	52	62	108	61	54	380	$20,178	$7,667,513	$758
Diabetes Short-term Complications	6	0	0	8	0	0	0	$0	$0	$0
Diabetes Long-term Complications	32	22	36	41	34	19	184	$17,807	$3,276,524	$324
TOTAL	**699**	**599**	**622**	**733**	**580**	**484**	**3,703**	**$19,010**	**$70,392,561**	**$7,007**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Clarksville 130862905				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$41,532	$19,256		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$19,256	$20,600	$22,391
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$19,256	$20,600	$22,391
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$20,600	$22,391
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$19,256	$20,600	$22,391
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$19,256	$20,600	$22,391
Grand Total Payments – CAT 4	**$41,532**	**$96,282**	**$102,999**	**$111,955**

Provider & TPI: Hunt Regional Medical Center Greenville 1310385-04

Domain A, Potentially Preventable Admissions
Hunt Regional Medical Center Greenville/131038504
Domain Description:
Potentially preventable admissions are a set of illnesses that could be avoided if patients have access to timely, outpatient primary care (Agency for Healthcare Research and Quality, 2009). Reducing potentially preventable admissions is an outcome quality measure that reflects the access to ambulatory care and the patients' participation with their care. Although not all potentially preventable admissions can be avoided, a decrease in the rate indicates healthcare delivery improvement.

Hunt Regional Medical Center will measure and report on the following potentially preventable admissions: (1) congestive heart failure, (2) diabetes, (3) behavioral health and substance abuse, (4) chronic obstructive pulmonary disease or asthma in adults, (5) hypertension, (6) pediatric asthma, (7) bacterial pneumonia immunization and (8) influenza immunization. The cumulative effect of Hunt Regional Medical Center's transform projects are expected to demonstrate a reduction in potentially preventable admissions.

Relationship to Category I, II, and III Projects
Building an improved healthcare delivery infrastructure is expected to dramatically reduce potentially preventable admissions. All of the transformation projects will have a synergistic and inter-related effect to improve health outcomes and patient experience at a reduced cost. Expanding primary care capacity (Project 1310385-04.1.1) is anticipated to reduce preventable admissions by managing acute illnesses at an early stage and by preventing disease exacerbations prior to the need for an acute care admission. Telehealth (Project 1310385-04.1.2) is expected to reduce potentially preventable admissions by managing heart failure in the outpatient setting and avoiding exacerbations requiring admission.

Program innovation and redesign is also expected to reduce potentially preventable admissions. Establishing a patient care navigation program (Project 1310385-04.2.1) and expanding care transitions programs (Project 1310385-04.2.2) will work independently and collectively to reduce preventable admissions by coordinating care to be provided in the appropriate setting at the right time and facilitating self-management of patients with chronic illnesses.

Achieving quality improvement outcomes is also expected to reduce preventable admissions. Managing cholesterol in patients with cardiovascular conditions (Improvement Target 1.6) is anticipated to reduce preventable admissions by preventing cardiovascular events requiring hospitalization. Reducing non-emergent ED visits (Improvement Target 9.2), all cause readmissions (Improvement Target 3.1) and CHF readmissions (Improvement Target 3.2) are also expected to reduce preventable admissions by preventing acute exacerbation of chronic diseases.

Domain Valuation:
Providing care in the right setting at the right time will result in decreased potentially preventable admissions. By enhancing performance improvement and reporting capacity (Project1310385-04.1.3) we anticipate a more robust quality program with the ability to identify, improve, monitor and maintain quality improvement initiatives that will drive healthcare delivery transformation. As identified in our community needs assessment, Region 1 has significant cost associated with potentially preventable admissions (CN. 4). The valuation approach for measuring potentially preventable admissions is associated with the cost of implementing systems to capture, measure and report required data. The costs associated with reporting this domain are the purchase of an electronic medical record interface, data repository and clinical analysts to measure and report quality data.

Domain B, 30-day Readmissions
Hunt Regional Medical Center Greenville/131038504
Domain Description:
Hospital readmission statistics are utilized as a quality outcome metric to benchmark effective hospital discharges and appropriate transitions of care. In a pioneering study published in *The New England Journal of Medicine* (Jencks, Williams and Coleman 2009), alarming statistics were discovered on the scope of hospital readmissions. Almost 20% of Medicare beneficiaries were readmitted to the hospital within 30 days from the prior discharge with 70% of these readmissions having a chronic medical condition.

Hunt Regional Medical Center will measure and report the following 30-day readmission rates: (1) congestive heart failure, (2) diabetes, (3) behavioral health and substance abuse, (4) chronic obstructive pulmonary disease, (5) stroke, (6) pediatric asthma and (7) all-cause. The transformation projects Hunt Regional Medical Center has selected will individually and collectively reduce 30-day readmissions while providing improved patient outcomes.

Relationship to Category I, II, and III Projects
Building an improved healthcare delivery infrastructure is expected to dramatically reduce hospital readmissions. All of the transformation projects will have a synergistic and inter-related effect that will result in reduced readmissions. Expanding primary care capacity (Project 1310385-04.1.1)and telehealth (Project 1310385-04.1.2) is anticipated to reduce readmissions by stabilizing and managing chronic illnesses prior to relapse and by providing follow-up from the hospital to make any needed changes in treatment.

Program innovation and redesign is also expected to reduce hospital readmissions. Establishing a patient care navigation program (Project 1310385-04.2.1) and expanding care transitions programs (Project 1310385-04.2.2) will work independently and collectively to reduce readmissions by coordinating care to be provided in the appropriate setting at the right time and educating and empowering patients to self-manage their health.

Achieving quality improvement outcomes is also expected to reduce preventable readmissions. Managing cholesterol in patients with cardiovascular conditions (Improvement Target 1.6) is anticipated to reduce preventable re-admissions by preventing cardiovascular events requiring re-hospitalization. Reducing non-emergent ED visits (Improvement Target 9.2) is also expected to reduce preventable readmissions by preventing exacerbation of chronic diseases. Reducing all-cause 30 day readmissions (Improvement Target 3.1) and CHF readmissions (Improvement Target 3.2) are directly linked to this domain. Reducing potentially preventable complications (Improvement Target 4.1) will reduce readmissions by reducing the amount of patients that require re-hospitalization following a complication.

Domain Valuation:
As identified in our community needs assessment, Region 1 has a high rate of people with chronic conditions (CN. 3) that frequently lead to hospital readmission. By enhancing performance improvement and reporting capacity (Project 1310385-04.1.3) we anticipate a more robust quality program with the ability to identify, improve, monitor and maintain quality improvement initiatives that will drive healthcare delivery transformation. The valuation approach for measuring potentially preventable readmissions is associated with the cost of implementing systems to capture, measure and report required data. The costs associated with reporting this domain are the purchase of an electronic medical record interface, data repository and clinical analysts to measure and report quality data.

Domain C, Potentially Preventable Complications
Hunt Regional Medical Center Greenville/131038504
Domain Description:
Potentially preventable complications are an often preventable and unexpected result of hospitalization that was not present on admission (Fuller, McCullough, Bao and Averill, 2009). Reducing complications is both a quality of care and reimbursement priority for hospitals. Reduced complications result in improved patient outcomes, mortality, and patient experience, reduced length of stay, resource utilization and cost. Hunt Regional Medical Center will measure and report all of the 64 potentially preventable complications as defined by 3M.

Relationship to Category I, II, and III Projects
Building an improved healthcare delivery infrastructure is expected to reduce potentially preventable complications. All of the transformation projects will have a synergistic and inter-related effect to improve health outcomes and patient experience at a reduced cost. Expanding primary care capacity (Project 1310385-04.1.1) and telehealth (Project 1310385-04.1.2) are expected to reduce preventable complications by providing ongoing, preventative care that will result in a healthier patient with fewer complications when the patient is admitted to the hospital.

Program innovation and redesign is also expected to reduce potentially preventable complications. Many preventable complications are the result of de-conditioning, a weakened immune system and unmanaged chronic conditions. Establishing a patient care navigation program (Project 1310385-04.2.1) and expanding care transitions programs (Project 1310385-04.2.2) will reduce preventable complications by resulting in a healthier, outpatient population with fewer unmanaged co-morbid conditions that will lead to reduced rates of complications.

Achieving quality improvement outcomes is also expected to reduce potentially preventable complications. Managing cholesterol in patients with cardiovascular conditions (Improvement Target 1.6) is anticipated to reduce some preventable complications including acute myocardial infarction (PPC # 11) and other cardiac complications (PPC #13) by preventing cardiovascular events in the hospitalized patient. Reducing potentially preventable complications is related to reducing all cause 30 day readmissions (Improvement Target 3.1) and CHF readmissions (Improvement Target 3.2) by preventing a complication that requires readmission.

Domain Valuation:
Measurement is a cornerstone of quality improvement. By enhancing performance improvement and reporting capacity (Project 1310385-04.1.3) we anticipate a more robust quality program with the ability to identify, improve, monitor and maintain quality improvement initiatives that will result in fewer potentially preventable complications. The valuation approach for measuring potentially preventable complications is associated with the cost of implementing systems to capture, measure and report required data. The costs associated with reporting this domain are the purchase of an electronic medical record interface, data repository and clinical analysts to measure and report quality data.

Domain D, Patient Centered Healthcare
Hunt Regional Medical Center Greenville/131038504
Domain Description:
Patient centered healthcare is a partnership between the patient/family and the healthcare team requiring patient engagement, education and communication to make decisions about healthcare based on patient preferences and needs. Patient centered healthcare results in improved patient outcomes and self-

management (Balik, Conway, Zipperer and Watson, 2011). Hunt Regional Medical Center will measure and report patient satisfaction including (1) care from doctors, (2) care from nurses, (3) the hospital environment, (4) when you left the hospital and (5) medication management including (a) medication to be taken and (b) medication to be discontinued.

Relationship to Category I, II, and III Projects

Building an improved healthcare delivery infrastructure is expected to foster patient centered healthcare. All of the transformation projects will have a synergistic and inter-related effect to improve patient centered care. Expanding primary care capacity (Project 1310385-04.1.1) and telehealth (Project 1310385-04.1.2) will improve the patient experience by offering outpatient treatment options and improved access to healthcare.

Program innovation and redesign is also expected to improve the patient experience. Establishing a patient care navigation program (Project 1310385-04.2.1) and expanding care transitions programs (Project 1310385-04.2.2) will improve patient centered healthcare offering additional support and collaborating with patients to manage their health.

Achieving quality improvement outcomes is expected to improve patient centered healthcare. Improved patient experience results in improved patient engagement which is necessary for life-style modification in conjunction with pharmacotherapy to reduce cholesterol in patients with cardiovascular conditions (Improvement Target 1.6). An improved patient experience is also related to reducing ED utilization (Improvement Target 9.2); all cause 30 day readmissions (Improvement Target 3.1) and CHF readmissions (Improvement Target 3.2) by improved self-management of chronic illness. Reducing potentially preventable complications (Improvement Target 4.1) will result in an improved patient experience

Domain Valuation:

A positive patient experience is associated with improved patient outcomes and engagement. As identified in our community needs assessment, effective healthcare delivery is a regional priory focus (CN. 6) that will result in an improved patient experience. The valuation approach for measuring patient experience is associated with the cost of implementing systems to capture, measure and report required data (Project 1310385-04.1.3). The costs associated with reporting this domain are an electronic medical record interface, data repository, patient surveys and administrative staff to report data.

Domain E, Emergency Department

Hunt Regional Medical Center Greenville/131038504

Domain Description:

Delayed ED throughput results in sub-optimal care and adverse events. ED throughput is a complex, multivariable process. One key factor contributing to ED throughput is the availability of inpatient beds for patients admitted through the ED. Other ED throughput factors are an increase in psychiatric ED patients and more medically complex ED patients requiring a more comprehensive evaluation (US Government Accountability Office, 2009). Hunt Regional has experienced all of the aforementioned ED throughput delays. Hunt Regional Medical Center will measure and report Emergency Department admit decision time to ED departure time for admitted patients. The cumulative effect of Hunt Regional Medical Center's transform projects are expected to improve ED throughput by reducing non-emergent ED visits.

Relationship to Category I, II, and III Projects

Building an improved healthcare delivery infrastructure is expected to improve Emergency Department throughput. Many of the transformation projects will have a synergistic and inter-related effect to improve ED

throughput. Expanding primary care capacity (Project 1310385-04.1.1) and telehealth (Project 1310385-04.1.2) will improve ED throughput by reducing non-emergent ED visits.

Program innovation and redesign is also expected to improve Emergency Department throughput. Establishing a patient care navigation program (Project 1310385-04.2.1) and expanding care transitions programs (Project 1310385-04.2.2) will transition non-emergent care that has historically been provided in the ED to a more appropriate outpatient setting.

Achieving quality improvement outcomes also relate to improved ED throughput. Reducing ED utilization (Improvement Target 9.2) is expected to improve ED throughput by decreasing the amount of non-emergent ED visits. Reducing potentially preventable complications (Improvement Target 4.1) will reduce ED throughput by reducing patient that present to the ED with a post hospitalization complication requiring care.

Domain Valuation:
Delayed ED throughput is a consequence of many factors including utilization of the ED for non-emergent visits (CN. 5) and a lack of urgent care access in primary care (CN. 1). Improving ED throughput is a priority to improve patient safety and receive timely care. The valuation approach for measuring Emergency Department length of stay time is associated with the cost of implementing systems to capture. measure and report required data (Project 1310385-04.1.3). The costs associated with reporting this domain are the purchase of an electronic medical record interface, data repository and clinical analysts to interpret and report quality data.

References:
Agency for Healthcare Research and Quality. (2009). *More Than 4 Million Potentially Preventable Admissions Cost Hospitals Nearly $31 Billion*. AHRQ News and Numbers, April 29, 2009. Rockville, MD. Available at: http://www.ahrq.gov/news/nn/nn042909.htm

Balik B, Conway J, Zipperer L, Watson J. *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. Available at: http://www.ihi.org/knowledge/Pages/IHIWhitePapers/AchievingExceptionalPatientFamilyExperienceInpatientHospitalCareWhitePaper.aspx

Fuller, R., McCullough, E., Bao, M., Averill, R. (2009). Estimating the costs of potentially preventable hospital acquired complications. Healthcare financing reviews. 30:4. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2914724/

Hospital Emergency Departments: Crowding Continues to Occur and Some Patients Wait Longer than Recommended Time Frames. (2009) United States Government Accountability Office. Report to the Chairman, Committee on Finance, U.S. Senate Available at: http://www.gao.gov/new.items/d09347.pdf

Jencks, S., Williams, M., & Coleman, E. (2009). Rehospitalizations among patients in the medicare fee-for-service program. *The New England Journal of Medicine, 360*(14), 1418-1428. Available at: http://www.commonwealthfund.org/Publications/In-the-Literature/2009/Apr/Rehospitalizations-Among-Patients-in-the-Medicare-Fee-for-Service.aspx

Category 4: Population-Focused Measures *Hunt Regional Medical Center* *131038504*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$269,848	$125,460		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 1 - Estimated Maximum Incentive Amount		$125,460	$134,521	$146,347
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 2 - Estimated Maximum Incentive Amount		$125,460	$134,521	$146,347
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 3 - Estimated Maximum Incentive Amount			$134,521	$146,347
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Medication Management				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)

Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 4 - Estimated Maximum Incentive Amount		$125,460	$134,521	$146,347
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 5 - Estimated Maximum Incentive Amount		$125,460	$134,521	$146,347
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$269,848	$627,300	$672,605	$731,735

Provider & TPI: ETMC Mt. Vernon 136140407

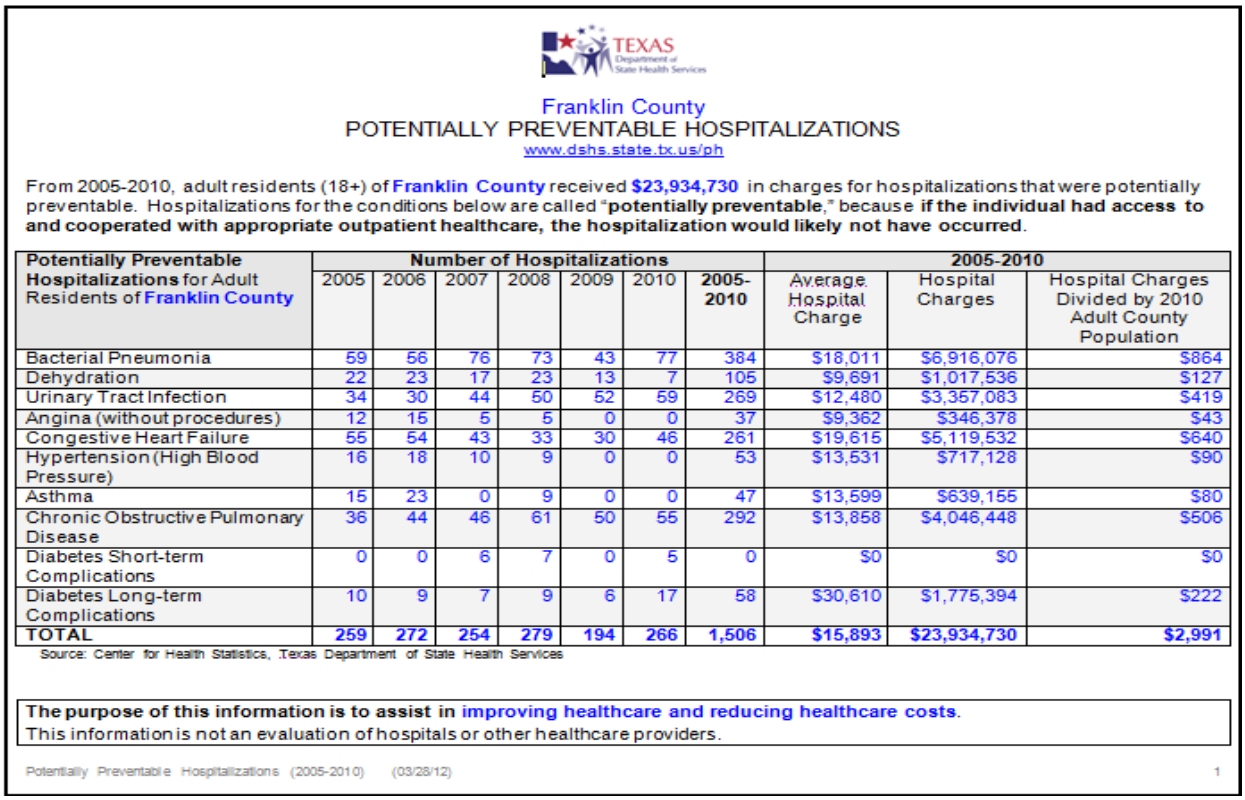
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable readmissions due to expanded primary care access and improved preventive care.

	Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will provide a patient-centered experience due to expanded primary care access and improved preventive care. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Mt. Vernon plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality

	and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Franklin County alone there were approximately 1,506 potentially preventable hospitalizations from 2005-2010. These patients represented more than $23M in charges. As one of the largest providers in Franklin County, ETMC Mt. Vernon's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $1.1M in savings over a six year period.



TEXAS Department of State Health Services

Franklin County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Franklin County** received **$23,934,730** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Franklin County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	59	56	76	73	43	77	384	$18,011	$6,916,076	$864
Dehydration	22	23	17	23	13	7	105	$9,691	$1,017,536	$127
Urinary Tract Infection	34	30	44	50	52	59	269	$12,480	$3,357,083	$419
Angina (without procedures)	12	15	5	5	0	0	37	$9,362	$346,378	$43
Congestive Heart Failure	55	54	43	33	30	46	261	$19,615	$5,119,532	$640
Hypertension (High Blood Pressure)	16	18	10	9	0	0	53	$13,531	$717,128	$90
Asthma	15	23	0	9	0	0	47	$13,599	$639,155	$80
Chronic Obstructive Pulmonary Disease	36	44	46	61	50	55	292	$13,858	$4,046,448	$506
Diabetes Short-term Complications	0	0	6	7	0	5	0	$0	$0	$0
Diabetes Long-term Complications	10	9	7	9	6	17	58	$30,610	$1,775,394	$222
TOTAL	**259**	**272**	**254**	**279**	**194**	**266**	**1,506**	**$15,893**	**$23,934,730**	**$2,991**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Mt. Vernon 136140407				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$12,964	$6,011		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$6,011	$6,430	$6,989
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$6,011	$6,430	$6,989
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$6,430	$6,989
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$6,011	$6,430	$6,989
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$6,011	$6,430	$6,989
Grand Total Payments – CAT 4	**$12,964**	**$30,053**	**$32,150**	**$34,945**

Provider & TPI: ETMC Crockett 137319306

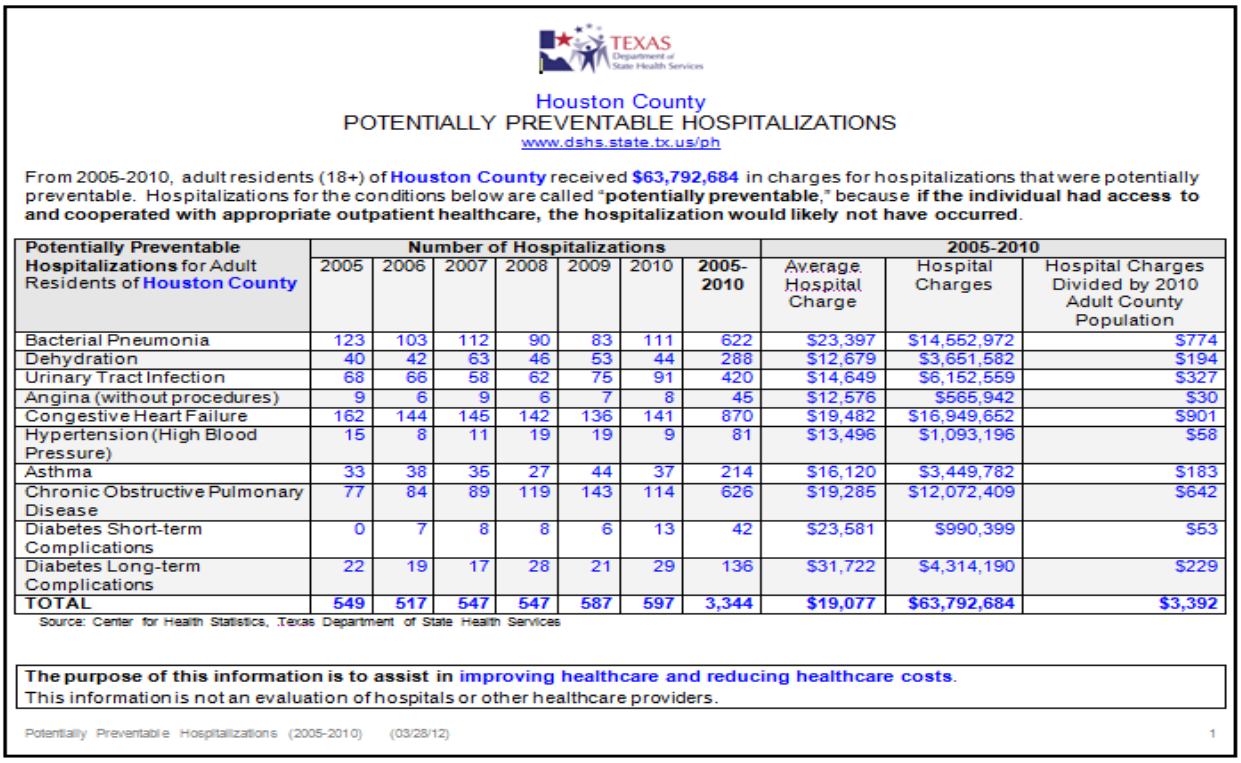
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease acute care hospitalizations for ambulatory care sensitive conditions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable readmissions due to expanded primary care access and improved preventive care.

	Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	ETMC plans to implement a Patient Care Navigation Program that will connect patients to primary and preventive care (2.9.1). The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate clinic setting where they can experience improved quality and decreased cost. The non-urgent patients will need to be referred to an available clinic. The ETMC clinic will begin offering extended hours and additional physician staffing (1.1.2) to meet the volume shift from the ED, as well as expansion of overall access to primary care for other segments of the population. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Connecting patients to primary and preventive care through patient navigation will promote higher quality healthcare to our patients at an overall lower cost to payers. Moving patients into the primary care clinic setting will provide a patient-centered experience due to expanded primary care access and improved preventive care. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	ETMC Crockett plans to implement a Patient Care Navigation Program (2.9.1) that will connect patients to primary and preventive care. The patient navigators will utilize ED medical screening protocol that shifts non-urgent patients to the more appropriate outpatient setting where they can experience improved quality

	and decreased cost. Establishing patients in a primary care clinic will help prevent admissions from ambulatory care sensitive conditions. Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Houston County alone there were approximately 3,344 potentially preventable hospitalizations from 2005-2010. These patients represented more than $63M in charges. As one of the largest providers in Houston County, ETMC Crockett's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $3M in savings over a six year period.



TEXAS Department of State Health Services

Houston County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Houston County** received **$63,792,684** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Houston County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	123	103	112	90	83	111	622	$23,397	$14,552,972	$774
Dehydration	40	42	63	46	53	44	288	$12,679	$3,651,582	$194
Urinary Tract Infection	68	66	58	62	75	91	420	$14,649	$6,152,559	$327
Angina (without procedures)	9	6	9	6	7	8	45	$12,576	$565,942	$30
Congestive Heart Failure	162	144	145	142	136	141	870	$19,482	$16,949,652	$901
Hypertension (High Blood Pressure)	15	8	11	19	19	9	81	$13,496	$1,093,196	$58
Asthma	33	38	35	27	44	37	214	$16,120	$3,449,782	$183
Chronic Obstructive Pulmonary Disease	77	84	89	119	143	114	626	$19,285	$12,072,409	$642
Diabetes Short-term Complications	0	7	8	8	6	13	42	$23,581	$990,399	$53
Diabetes Long-term Complications	22	19	17	28	21	29	136	$31,722	$4,314,190	$229
TOTAL	**549**	**517**	**547**	**547**	**587**	**597**	**3,344**	**$19,077**	**$63,792,684**	**$3,392**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Crockett 137319306				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$51,451	$23,855		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$23,855	$25,520	$27,739
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$23,855	$25,520	$27,739
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$25,520	$27,739
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$23,855	$25,520	$27,739
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$23,855	$25,520	$27,739
Grand Total Payments – CAT 4	**$51,451**	**$119,276**	**$127,598**	**$138,693**

Provider & TPI: ETMC Pittsburg 138374715

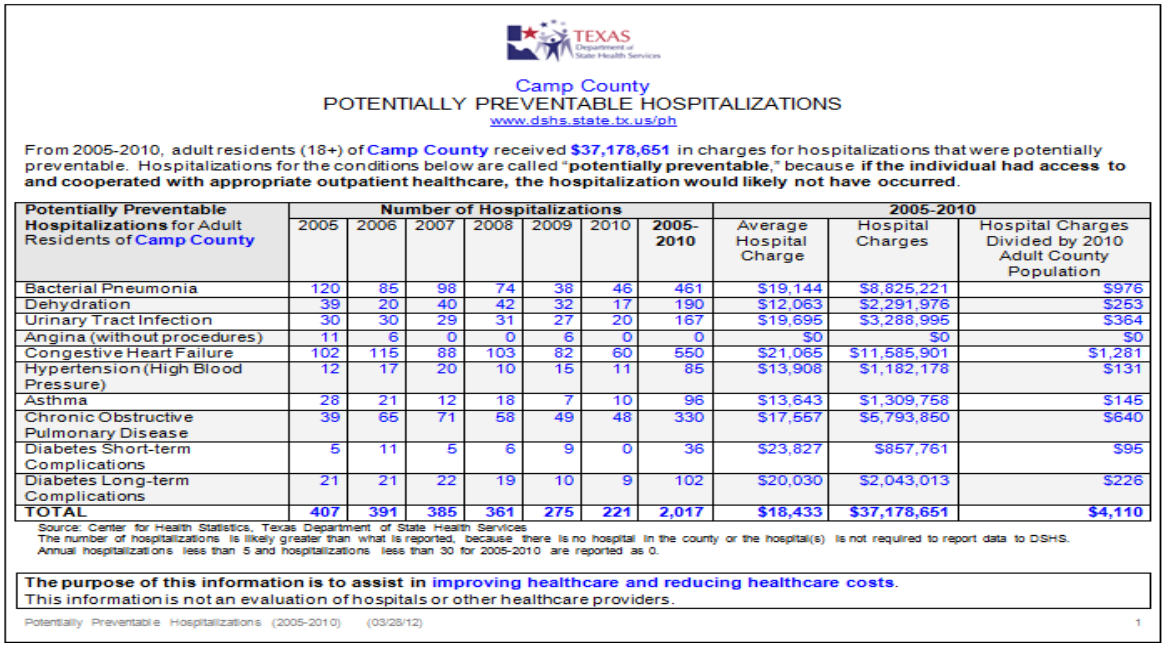
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	The Pittsburg community has a shortage of specialty care access and specific need for a general surgeon and orthopedic surgeon. Recruitment of a general and orthopedic surgeon (1.9.2) will expand specialty access to those that have untreated surgery needs and improve the overall health of the population. We propose to increase the overall quality of care and improve the health status of our target population—general and orthopedic surgery patients at ETMC Pittsburg. Recruiting a general and orthopedic surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The related category 3 outcome measure is IT-4.4: Surgical site infections (SSI) rates in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC Pittsburg's goal is to reduce the number of surgical site infections (SSI) for general and orthopedic surgery cases. ETMC plans to decrease the surgical site infection (SSI) rate —for general and orthopedic surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively. We propose to increase the overall quality of care and improve the health status of our target population—general and orthopedic surgery patients at ETMC Pittsburg. Recruiting a general and orthopedic surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. With quality improvement oversight, a local general surgeon and orthopedic surgeon and will decrease 30 day potentially preventable readmissions. Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	The related category 3 outcome measure is IT-4.4: Surgical site infections (SSI) rates in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC Pittsburg's goal is to reduce the number of surgical site infections (SSI) for general and orthopedic surgery cases. ETMC plans to decrease the surgical site infection (SSI) rate —for general and orthopedic surgery patients—by 4% and 8% in demonstration years 4 and 5, respectively.

	We propose to increase the overall quality of care and improve the health status of our target population—general and orthopedic surgery patients at ETMC Pittsburg. Recruiting a general and orthopedic surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. With quality improvement oversight, a local general surgeon and orthopedic surgeon and will decrease the SSI rate and potentially preventable complications. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	The Pittsburg community has a shortage of specialty care access and specific need for a general surgeon and orthopedic surgeon. Recruitment of a general and orthopedic surgeon (1.9.2) will expand specialty access to those that have untreated surgery needs and improve the overall health of the population. We propose to increase the overall quality of care and improve the health status of our target population—general and orthopedic surgery patients at ETMC Pittsburg. Recruiting a general and orthopedic surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. Through recruiting a general and orthopedic surgeon, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	We propose to increase the overall quality of care and improve the health status of our target population—general and orthopedic surgery patients at ETMC Pittsburg. Recruiting a general and orthopedic surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. Providing expanded access to a general and orthopedic surgeon will decrease unnecessary utilization of the ED and create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Camp County alone there were approximately 2,017 potentially preventable hospitalizations from 2005-2010. These patients represented more than $37M in charges. As one of the largest providers in Camp County, ETMC Pittsburg's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5%

decrease in potentially preventable admissions alone would be valued at over $1.85M in savings over a six year period.



TEXAS Department of State Health Services

Camp County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Camp County** received **$37,178,651** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Camp County**	Number of Hospitalizations							2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	120	85	98	74	38	46	461	$19,144	$8,825,221	$976
Dehydration	39	20	40	42	32	17	190	$12,063	$2,291,976	$253
Urinary Tract Infection	30	30	29	31	27	20	167	$19,695	$3,288,995	$364
Angina (without procedures)	11	6	0	0	6	0	0	$0	$0	$0
Congestive Heart Failure	102	115	88	103	82	60	550	$21,065	$11,585,901	$1,281
Hypertension (High Blood Pressure)	12	17	20	10	15	11	85	$13,908	$1,182,178	$131
Asthma	28	21	12	18	7	10	96	$13,643	$1,309,758	$145
Chronic Obstructive Pulmonary Disease	39	65	71	58	49	48	330	$17,557	$5,793,850	$640
Diabetes Short-term Complications	5	11	5	6	9	0	36	$23,827	$857,761	$95
Diabetes Long-term Complications	21	21	22	19	10	9	102	$20,030	$2,043,013	$226
TOTAL	**407**	**391**	**385**	**361**	**275**	**221**	**2,017**	**$18,433**	**$37,178,651**	**$4,110**

Source: Center for Health Statistics, Texas Department of State Health Services
The number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS.
Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

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Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
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Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Pittsburg 138374715				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$62,012	$28,752		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$28,752	$30,758	$33,432
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$28,752	$30,758	$33,432
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$30,758	$33,432
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$28,752	$30,758	$33,432
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$28,752	$30,758	$33,432
Grand Total Payments – CAT 4	**$62,012**	**$143,759**	**$153,789**	**$167,162**

Provider & TPI: Titus Regional Medical Center 138913209

Project Description:
The overall objective of Category 4 is to demonstrate Titus Regional Medical Center's progression of improved health measures through the tracking of the following domains:

Domain 1: Potentially Preventable Admissions (8 measures)
TRMC plans to open a Family Care Center (138913209.1.1) which will provide preventive care for our patients. As a result of limited primary care, many patients are cared for exclusively in specialty care clinics and/or emergency rooms; these settings are not designed to provide comprehensive assessment, preventive care and coordination. With expanded primary care capacity, more patients can have access to primary and preventive care resulting in reducing preventable admissions.

TRMC plans to improve access to specialty care through the hiring of an endocrinologist and increased diabetes education (138913209.1.2). Diabetes education and physician monitoring will directly correlate to reduction in potentially preventable admissions.

TRMC plans to improve to improve access to specialty care by also hiring a neurologist for the area and the achieving of a Level III Primary Stroke Center (138913209.1.1). The education and preventive care available related to the stroke center along with the addition of a neurologist will assist in reducing potentially preventable admissions.

Through the implementation of our projects, we expect to see a decrease in overall potentially preventable admissions.

Potentially Preventable Readmissions – 30 days (7 measures)
Access to primary care access through the Family Care Center (138913209.1.1) will offer the residents of the target area an option for follow-up and preventive healthcare after an admission. The hiring of the endocrinologist (138913209.1.2) will offer follow-up for our patients with diabetes and will also be addressed in IT-3.3 Diabetes 30 Day Readmission Rate (138913209.3.4). The hiring of a neurologist (138913209.1.3) will assist in the reduction of readmissions related to strokes as well as addressing this in IT-3.7 Stroke (CVA) 30 day readmission rate (138913209.3.6).

Through the implementation of our projects, we expect to see a decrease in overall potentially preventable readmissions.

Domain 3: Potentially Preventable Complications (64 measures)
Access to primary care (138913209.1.1) through Family Care Center will allow the residents of the target population to maintain preventive healthcare and assist in identification of risks. Hiring an endocrinologist (138913209.1.2) provides expansion of services for diabetic patients, provides preventive care management for their chronic condition, and creates a follow-up option for patients discharged from a diabetes related inpatient stay. Managing the care of diabetic patients will improve health outcomes, decrease the cost of care, and decrease potentially preventable complications from

diabetes. In addition, expanded neurological coverage (138913209.1.3) further increases access to specialty care capacity and broadens the full spectrum of specialty coverage. In addition to these projects, TRMC plans an initiative related to cost accounting (138913209.2.1) with a focus on IT-5.2 Per Episode Cost of Care related to CHF (138913209.3.3). This analysis of the costs related to CHF will keep a focus on CHF extending outside of the just the cost benefits. These projects Managing the care of our patients will improve health outcomes while decreasing potentially preventable complications and lowering the cost of care.

Through implementation of our projects, we expect to see a decrease in potentially preventable complications for diabetes and CHF. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.

Domain 4: Patient-Centered Healthcare (2 measures)

Access to primary care through the Family Care Center (138913209.1.1) creates access for certain demographics of this area who do not have accessible healthcare. In addition, the Family Care Center will improve Patient Satisfaction of for the patients due to availability of provider and referral networks.

TRMC also plans to introduce a process flow improvement in the emergency room (138913209.2.2) through the introduction of a Rapid Medical Evaluation ("RME") system for the ED patient flow. This process flow will dramatically improve wait times and the flow of patients through the system improving patient satisfaction.

Through implementation of our projects, we expect to see an increase of patient satisfaction scores .

Domain 5: Emergency Department (1 measure)

TRMC plans to open a Family Care Center (138913209.1.1) offering lower level users of the Emergency Room an opportunity to seek a healthcare in the right setting. In addition, extended hours will allow for treatment of care in the appropriate setting. Hiring a neurologist for the area and the achieving of a Level III Primary Stroke Center (138913209.1.1) will allow TRMC Emergency Department to treat more patients reducing the transfer of patients from TRMC and providing access to a stroke center for residents of our area not currently within 60 minutes of a stroke center.

TRMC also plans to introduce a process flow improvement in the emergency room (138913209.2.2) through the introduction of a Rapid Medical Evaluation ("RME") system for the ED patient flow. This process flow will dramatically improve wait times and the flow of patients through the system improving patient satisfaction.

Preventing unnecessary utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients.

Project Valuation:

To allocate the amount of monies for this category, TRMC created an allocation percentage based on all six domains and their individual achievement of waiver goals, addressing of community needs, data collection scope/size and data collection investment. Methodology for ranking was based on the following criteria:

- **Achieves Waiver Goals:** Ranked on a scale of 1 to 5 with 1 as minimal impact on waiver goals and 5 as greatest impact on all waiver goals as compared to each project.
- **Addresses Community Needs:** Ranked on a scale of 1 to 5 with 1 as minimal impact on community needs and 5 as greatest impact on community needs.
- **Project Scope:** Ranked on a scale of 1 to 5 with 1 as a small number/percent of time to collect data and population impacted and 5 as a large number/percent of time to collect data and population impacted.
- **Project Investment:** Ranked on a scale of 1 to 5 with 1 as small investment required for collection of the data and 5 as large investment required for collection of the data.

The above calculation resulted in the following summary of domains:

	Achieves Waivers Goal	Addresses Community Needs	Domain's Scope	Domain's Investment	Total	%
Domain 1: Potentially Preventable Admissions	5	5	3	2	**15**	16.7%
Domain 2: Potentially Preventable Readmissions – 30 days	5	4	4	3	**16**	17.8%
Domain 3: Potentially Preventable Complications	5	3	5	5	**18**	20.0%
Domain 4: Patient-Centered Healthcare	2	3	5	3	**13**	14.4%
Domain 5: Emergency Department	5	5	2	2	**14**	15.6%
Domain 6: Children and Adult Core Measures	2	2	5	5	**14**	15.6%
					90	100.0%

As shown in the chart below, The Texas Department of State Health Services suggests Titus County incurs $5.5 million dollars in Potentially Preventable Hospitalizations on annual basis. A 5% reduction is $275,000 in potential savings on an annual basis.

Titus County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Titus County** received **$32,856,899** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Titus County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	96	143	149	119	7	15	529	$17,379	$9,193,622	$409
Dehydration	16	22	33	30	5	0	106	$11,774	$1,248,040	$56
Urinary Tract Infection	39	61	53	41	10	17	221	$13,231	$2,924,125	$130
Angina (without procedures)	12	0	9	9	0	0	30	$12,918	$387,547	$17
Congestive Heart Failure	86	115	86	96	19	23	425	$20,553	$8,735,194	$389
Hypertension (High Blood Pressure)	22	20	26	17	0	0	85	$11,879	$1,009,681	$45
Asthma	8	17	19	11	0	0	55	$14,691	$807,979	$36
Chronic Obstructive Pulmonary Disease	29	30	37	75	11	16	198	$18,925	$3,747,083	$167
Diabetes Short-term Complications	9	10	11	16	0	0	46	$18,920	$870,319	$39
Diabetes Long-term Complications	17	18	23	24	9	5	96	$40,972	$3,933,308	$175
TOTAL	**334**	**436**	**446**	**438**	**61**	**76**	**1,791**	**$18,346**	**$32,856,899**	**$1,463**

Source: Center for Health Statistics, Texas Department of State Health Services
The number of hospitalizations is likely greater than what is reported, because there is no hospital in the county or the hospital(s) is not required to report data to DSHS.
Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

Category 4: Population-Focused Measures *Titus Regional Medical Center* *138913209*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$114,792	$80,077		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 1 - Estimated Maximum Incentive Amount		$66,732	$71,569	$77,868
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 2 - Estimated Maximum Incentive Amount		$71,181	$76,340	$83,060
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 3 - Estimated Maximum Incentive Amount			$85,883	$93,442
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Medication Management				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)

Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 4 - Estimated Maximum Incentive Amount		$57,834	$62,026	$67,486
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 5 - Estimated Maximum Incentive Amount		$62,283	$66,798	$72,677
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		1 (10/1 – 3/31)	1 (10/1 – 3/31)	1 (10/1 – 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 -9/30)	2 (4/1 -9/30)	2 (4/1 -9/30)
Domain 6 - Estimated Maximum Incentive Amount		$62,283	$66,798	$72,677
Grand Total Payments Across Category 4	$114,792	$400,390	$429,414	$467,211

Provider & TPI: ETMC Gilmer 168447401

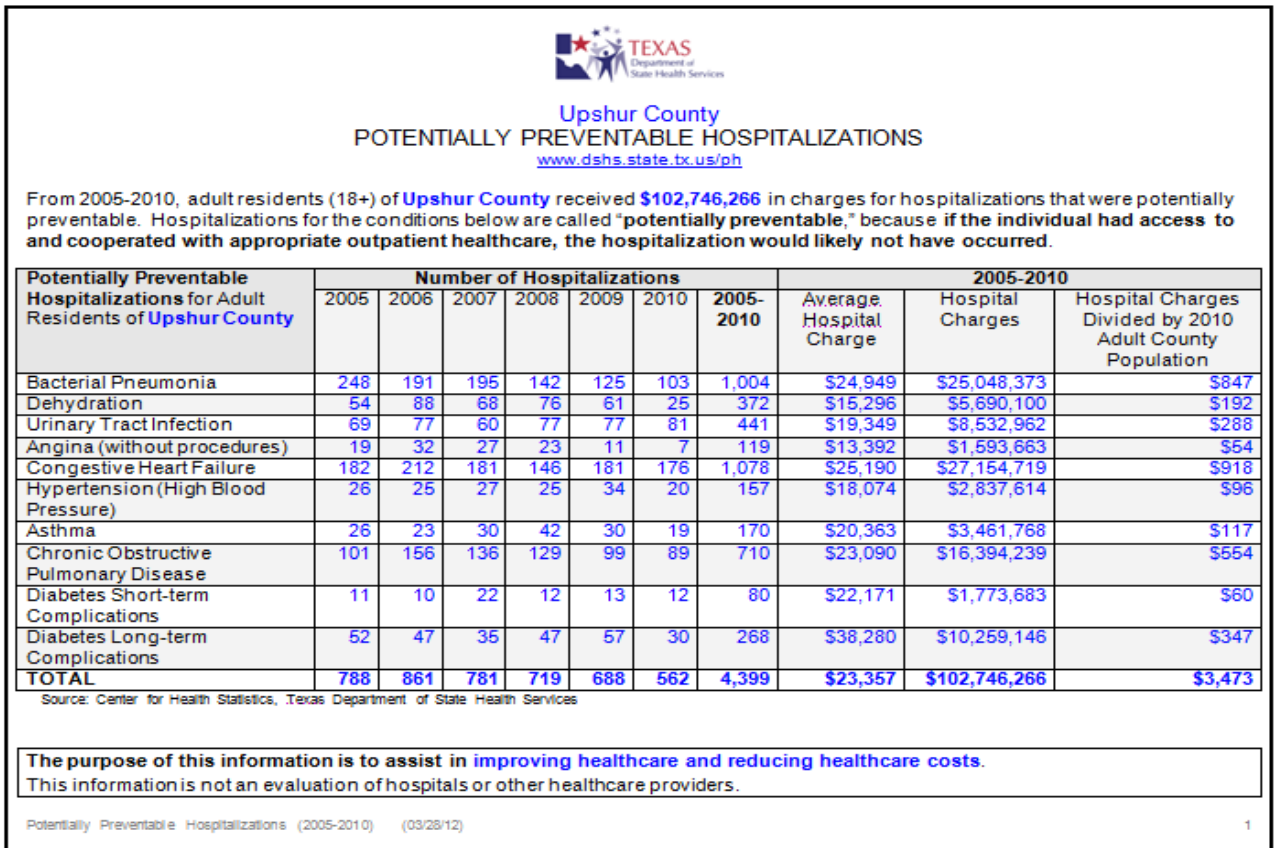
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	The ETMC Gilmer clinic will begin offering extended clinic hours and additional physician staffing (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years through a series of primary care expansion initiatives. Our goal is to decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years by 3% in DY 4 and 6% in DY 5. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable admissions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC Gilmer clinic will begin offering additional physician staffing and extended clinic hours (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional physicians and providing more appointment availability through extended hours will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable 30 day readmissions due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.

Potentially Preventable Complications	The ETMC Gilmer clinic will begin offering additional physician staffing and extended clinic hours (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. The related category 3 outcome measure is IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate in the Potentially Preventable Admissions domain (OD-2). ETMC's goal is to reduce the number of acute care hospitalizations for ambulatory care sensitive conditions and prevent health complications through a series of primary care expansion initiatives. We propose to increase the overall quality of care and improve the health status of our target population—new ETMC primary care clinic patients. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable complications due to expanded primary care access and improved preventive care. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	Increasing the overall quality of care and improving the health status of our target population—new ETMC primary care clinic patients—will ensure patient-centered healthcare. Recruiting additional physicians will promote higher quality healthcare to our patients at an overall lower cost to payers. Increased staffing will decrease potentially preventable admissions while providing care in a patient-centered manner. Through additional physician recruitment and expanded clinic hours, we expect to see an increase in patient satisfaction and medication management scores. Extended hours and availability provides more access to care in a patient-centered manner. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	The ETMC Gilmer clinic will begin offering additional physician staffing and extended clinic hours (1.1.2) to meet the needs of the underserved community by providing expanded appointment availability that will increase access to preventive primary and care. Increasing the overall quality of care and improving the health status of our target population—new ETMC primary care clinic patients—will prevent unnecessary utilization of the ED. Recruiting additional physicians will promote higher quality

	healthcare to our patients at an overall lower cost to payers. Increased staffing will promote preventive care in the clinic setting, rather than the ED. Preventing unnecessary ED utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. Extended hours and more appointment availability both prevent unnecessary ED utilization. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Upshur County alone there were approximately 4,399 potentially preventable hospitalizations from 2005-2010. These patients represented more than $102M in charges. As one of the largest providers in Upshur County, ETMC Gilmer's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $5M in savings over a six year period.



TEXAS Department of State Health Services

Upshur County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Upshur County** received **$102,746,266** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Upshur County**	Number of Hospitalizations						2005-2010	2005-2010		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	248	191	195	142	125	103	1,004	$24,949	$25,048,373	$847
Dehydration	54	88	68	76	61	25	372	$15,296	$5,690,100	$192
Urinary Tract Infection	69	77	60	77	77	81	441	$19,349	$8,532,962	$288
Angina (without procedures)	19	32	27	23	11	7	119	$13,392	$1,593,663	$54
Congestive Heart Failure	182	212	181	146	181	176	1,078	$25,190	$27,154,719	$918
Hypertension (High Blood Pressure)	26	25	27	25	34	20	157	$18,074	$2,837,614	$96
Asthma	26	23	30	42	30	19	170	$20,363	$3,461,768	$117
Chronic Obstructive Pulmonary Disease	101	156	136	129	99	89	710	$23,090	$16,394,239	$554
Diabetes Short-term Complications	11	10	22	12	13	12	80	$22,171	$1,773,683	$60
Diabetes Long-term Complications	52	47	35	47	57	30	268	$38,280	$10,259,146	$347
TOTAL	**788**	**861**	**781**	**719**	**688**	**562**	**4,399**	**$23,357**	**$102,746,266**	**$3,473**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new

physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Gilmer 168447401				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$22,352	$10,601		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$10,601	$11,554	$12,649
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$10,601	$11,554	$12,649
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$11,554	$12,649
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$10,601	$11,554	$12,649
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$10,601	$11,554	$12,649
Grand Total Payments – CAT 4	**$22,352**	**$53,007**	**$57,770**	**$63,244**

Provider & TPI: Red River Regional Hospital 177870603

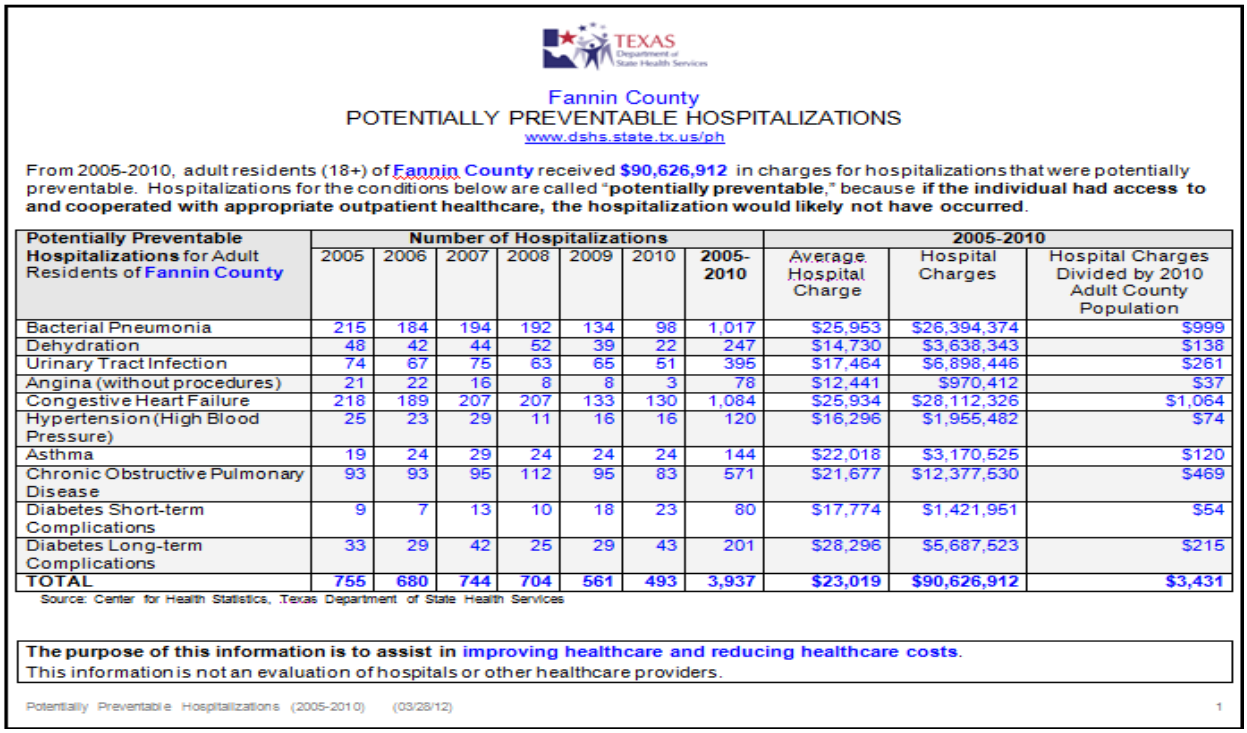
Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	The RRRH clinic will begin offering extended hours and additional physician staffing (177870603.1.1) to provide expanded access to primary care and preventive services. The expansion of access to primary care providers will help patients manage chronic disease and improve patient health outcomes. The expansion of primary care access will decrease the number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (177870603.3.1) due to enhanced physician-patient relationships, preventive care, and chronic disease management. Providing primary care to more patients through our extended hours and staffing will allow RRRH to make a significant impact in disease management. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2), decrease the cost of acute inpatient care, and decrease potentially preventable admissions. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	Providing primary care to more patients through our extended hours and staffing will allow RRRH to make a significant impact in disease management. Diabetes management provides expansion of services for diabetic patients and creates a follow-up option for patients discharged from a diabetes related inpatient stay. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2), decrease the cost of acute inpatient care, and decrease potentially preventable 30-day readmissions. While clinic hours and staffing reduce preventable admissions, redesigning to improve the patient experience (177870603.2.2) will improve overall patient satisfaction and decrease potentially preventable 30-day readmissions. We will increase patient satisfaction scores (177870603.3.3) by implementing a mix of administrative rounding and discharge planning programs. Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	Providing primary care to more patients through our extended hours and staffing (177870603.1.1) will allow RRRH to make a significant impact in disease management

	and overall preventive care. Diabetes management provides expansion of services for diabetic patients and creates a follow-up option for patients discharged from a diabetes related inpatient stay. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2), decrease the cost of acute inpatient care, and decrease potentially preventable complications from diabetes. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for diabetes and other new clinic patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	Redesigning to improve the patient experience (177870603.2.2) unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores by implementing administrative rounding and discharge planning programs. Patient-centered healthcare is proven to lead to improved outcomes and decreased cost. Through implementation of our patient experience project, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	The RRRH clinic will begin offering extended hours and additional physician staffing (177870603.1.1) to provide expanded access to primary care and preventive services. The expansion of access to primary care providers will help patients manage chronic disease and improve patient health outcomes. The expansion of primary care access will decrease unnecessary ED visits due to enhanced physician-patient relationships, preventive care, and chronic disease management. Managing the care of diabetic patients (177870603.2.1) will improve health outcomes (177870603.3.2), decrease the cost of acute inpatient care, and decrease unnecessary utilization of the ED through preventive care. Redesigning to improve the patient experience (177870603.2.2) unites all the other efforts by improving overall patient satisfaction. We will increase patient satisfaction scores and prevent post-discharge ED visits by implementing administrative rounding and discharge planning programs. Preventing unnecessary ED utilization of clinic appropriate patients will create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Fannin County alone there were approximately 3,937 potentially

preventable hospitalizations from 2005-2010. These patients represented more than $90M in charges. As one of the largest providers in Fannin County, Red River Regional Hospital's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $4.5M in savings over a six year period.



TEXAS Department of State Health Services

Fannin County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of Fannin County received **$90,626,912** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Fannin County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	215	184	194	192	134	98	1,017	$25,953	$26,394,374	$999
Dehydration	48	42	44	52	39	22	247	$14,730	$3,638,343	$138
Urinary Tract Infection	74	67	75	63	65	51	395	$17,464	$6,898,446	$261
Angina (without procedures)	21	22	16	8	8	3	78	$12,441	$970,412	$37
Congestive Heart Failure	218	189	207	207	133	130	1,084	$25,934	$28,112,326	$1,064
Hypertension (High Blood Pressure)	25	23	29	11	16	16	120	$16,296	$1,955,482	$74
Asthma	19	24	29	24	24	24	144	$22,018	$3,170,525	$120
Chronic Obstructive Pulmonary Disease	93	93	95	112	95	83	571	$21,677	$12,377,530	$469
Diabetes Short-term Complications	9	7	13	10	18	23	80	$17,774	$1,421,951	$54
Diabetes Long-term Complications	33	29	42	25	29	43	201	$28,296	$5,687,523	$215
TOTAL	**755**	**680**	**744**	**704**	**561**	**493**	**3,937**	**$23,019**	**$90,626,912**	**$3,431**

Source: Center for Health Statistics, Texas Department of State Health Services

The purpose of this information is to assist in improving healthcare and reducing healthcare costs.
This information is not an evaluation of hospitals or other healthcare providers.

Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
Abdominal pain	4,447	247	1,378	558	82
Upper respiratory tract infection	3,259	102	553	542	82
Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures Red River Regional Hospital 177870603				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$55,183	$26,173		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$26,173	$28,525	$31,228
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$26,173	$28,525	$31,228
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$28,525	$31,228
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$26,173	$28,525	$31,228
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$26,173	$28,525	$31,228
Grand Total Payments – CAT 4	**$55,183**	**$130,866**	**$142,627**	**$156,141**

Provider & TPI: ETMC Henderson 208843701

Domain Descriptions:

Domain	Description
Potentially Preventable Admissions	The ETMC Henderson clinic will begin offering extended hours (1.1.2) to expand overall access to primary care in Rusk County and beyond. The shortage of primary care providers creates a need for more primary care capacity and access that extended clinic hours will help alleviate. In addition to a primary care need, there is also great need for a general surgeon in the Henderson area. Recruitment of a general surgeon (1.9.2) will expand specialty access to those that have untreated general surgery needs and improve the overall health of the population. We propose to increase the overall quality of care and improve the health status of our target population—general surgery patients at ETMC Henderson. Recruiting a general surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. A local general surgeon and quality improvement oversight will decrease surgical site infections (SSI) rates and potentially preventable admissions. Through implementation of our projects, we expect to see a decrease in overall potentially preventable admissions. The first year of implementation may cause an immediate increase of admissions due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of preventable admissions.
Potentially Preventable Readmissions – 30 days	The ETMC Henderson clinic will begin offering extended hours (1.1.2) to expand overall access to primary care in Rusk County and beyond. The shortage of primary care providers creates a need for more primary care capacity and access that extended clinic hours will help alleviate. In addition to a primary care need, there is also great need for a general surgeon in the Henderson area. Recruitment of a general surgeon (1.9.2) will expand specialty access to those that have untreated general surgery needs and improve the overall health of the population. The related category 3 outcome measure is IT-4.4: Surgical site infections (SSI) rates in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC Henderson's goal is to reduce the number of surgical site infections (SSI) for general surgery cases. We propose to increase the overall quality of care and improve the health status of our target population—general surgery patients at ETMC Henderson. Recruiting a general surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. A local general surgeon and quality improvement oversight will decrease surgical site infections (SSI) rates and potentially preventable 30 day readmissions.

	Through implementation of our projects, we expect to see a decrease in overall potentially preventable 30 day readmissions. After planning and implementation, years 3-5 should experience a steady decline of preventable readmissions.
Potentially Preventable Complications	Recruitment of a general surgeon (1.9.2) will expand specialty access to those that have untreated general surgery needs and improve the overall health of the population. The related category 3 outcome measure is IT-4.4: Surgical site infections (SSI) rates in the Potentially Preventable Complications and Healthcare Acquired Conditions domain (OD-4). ETMC Henderson's goal is to reduce the number of surgical site infections (SSI) for general surgery cases. We propose to increase the overall quality of care and improve the health status of our target population—general surgery patients at ETMC Henderson. Recruiting a general surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. A local general surgeon and quality improvement oversight will decrease surgical site infections (SSI) rates and potentially preventable complications. Through implementation of our projects, we expect to see a decrease in potentially preventable complications for our patients. The first year of implementation may cause an immediate increase of complications due to expanded access and diagnosis; however, years 3-5 should experience a steady decline of potentially preventable complications.
Patient-Centered Healthcare	We propose to increase the overall quality of care and improve the health status of our target population—general surgery patients at ETMC Henderson. Recruiting a general surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. A local general surgeon and quality improvement oversight will decrease surgical site infections (SSI) rates. Through recruitment of a surgeon and extended clinic hours, we expect to see an increase in patient satisfaction and medication management scores. After planning and implementation, years 3-5 should experience a steady improvement in HCAHPS scores.
Emergency Department	We propose to increase the overall quality of care and improve the health status of our target population—general surgery patients at ETMC Henderson. Recruiting a general surgeon will increase access to specialty care and promote higher quality healthcare to our patients at an overall lower cost to payers. In addition, provided extended clinic hours will allow patients to seek primary care in the most appropriate clinic setting—preventing over utilization of the ED. Providing expanded access to a general surgeon and extended clinic hours will decrease unnecessary utilization of the ED and create a more efficient environment to care for truly emergent patients. The resulting bed availability and maximized efficiency should decrease admit decision time to ED departure time for admitted patients for years 3-5.

Domain Valuation: As shown in the chart below, The Texas Department of State Health Services suggests that in Rusk County alone there were approximately 4,758 potentially preventable hospitalizations from 2005-2010. These patients represented more than $97M in charges. As one of the largest providers in Rusk County, ETMC Henderson's projects can make a significant impact on the cost of potentially preventable admissions and readmissions. A 5% decrease in potentially preventable admissions alone would be valued at over $4.8M in savings over a six year period.

TEXAS Department of State Health Services

Rusk County
POTENTIALLY PREVENTABLE HOSPITALIZATIONS
www.dshs.state.tx.us/ph

From 2005-2010, adult residents (18+) of **Rusk County** received **$97,234,829** in charges for hospitalizations that were potentially preventable. Hospitalizations for the conditions below are called "**potentially preventable**," because **if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred**.

Potentially Preventable Hospitalizations for Adult Residents of **Rusk County**	**Number of Hospitalizations**							**2005-2010**		
	2005	2006	2007	2008	2009	2010	**2005-2010**	Average Hospital Charge	Hospital Charges	Hospital Charges Divided by 2010 Adult County Population
Bacterial Pneumonia	241	148	153	118	178	151	989	$23,866	$23,603,099	$576
Dehydration	75	50	68	52	44	32	321	$16,711	$5,364,157	$131
Urinary Tract Infection	100	112	88	97	134	115	646	$15,915	$10,281,330	$251
Angina (without procedures)	25	31	10	0	8	7	81	$12,612	$1,021,570	$25
Congestive Heart Failure	255	210	228	161	200	226	1,280	$20,564	$26,322,140	$643
Hypertension (High Blood Pressure)	38	37	30	25	22	28	180	$19,699	$3,545,907	$87
Asthma	47	26	30	29	37	31	200	$15,895	$3,179,078	$78
Chronic Obstructive Pulmonary Disease	147	125	102	109	148	138	769	$17,425	$13,400,082	$327
Diabetes Short-term Complications	13	8	13	12	16	19	81	$21,711	$1,758,592	$43
Diabetes Long-term Complications	32	30	44	26	43	36	211	$41,511	$8,758,875	$214
TOTAL	**973**	**777**	**766**	**629**	**830**	**783**	**4,758**	**$20,436**	**$97,234,829**	**$2,374**

Source: Center for Health Statistics, Texas Department of State Health Services

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Potentially Preventable Hospitalizations (2005-2010) (03/28/12) 1

In Table 5 below, a North Carolina Medical Journal article on ED vs. Clinic cost concludes that "charges in the ED were 320%-728% higher than those in the clinic, allowing for potential savings of 69%-86% had ACSC-related [Ambulatory Care-Sensitive Conditions] visits been treated in clinics instead of in EDs (McWilliams et al.)." The relationships built with our new physicians will promote healthier lifestyles, improve chronic disease management, facilitate effective follow up care with treatment plans, and decrease avoidable inpatient admissions. The article suggests there is an average of 78% savings for a clinic visit instead of an ED visit.

TABLE 5.
Comparison of Costs Between Clinic and Emergency Department (ED) Settings for the Most Common Ambulatory Care–Sensitive Conditions (ACSCs) Treated in EDs

ACSC	ACSC-related ED visits, no.	Average charge in $, by setting		Percentage increase[a]	Percentage savings[b]
		Clinic	ED		
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Headache	2,078	189	1,219	645	84
Chest pain	2,061	284	846	298	66
Urinary tract infection	1,638	227	1,368	603	83
Vomiting	1,632	127	861	678	85
Sore throat	1,561	188	575	306	67
Limb pain	1,305	232	777	335	70
Ear infection	1,271	98	429	438	77
Oral soft-tissue disease	1,189	118	432	366	73

[a]Data are percentage increase in costs associated with treatment of ACSCs in ED rather than in clinics.
[b]Data are percentage savings in costs had ACSCs been treated in clinics rather than in EDs.

(McWilliams, A.; Tapp, H.; Barker, J.; and Dulin, M. (2011). Cost Analysis of the Use of EDs for Primary Care Services. North Carolina Medical Journal, 72(4), 265-271.)

Category 4: Population-Focused Measures ETMC Henderson 208843701				
	DY2 (10/1/2012-9/30/2013)	DY2 (10/1/2013-9/30/2014)	DY2 (10/1/2014-9/30/2015)	DY2 (10/1/2015-9/30/2016)
Capability to Report Category 4	Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, and 5.	Milestone: Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$37,061	$17,183		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 1- Estimated Maximum Incentive Amount		$17,183	$18,382	$19,980
Domain 2: Potentially Preventable Readmissions (30-day readmissions rates) (PPRs)				
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 2- Estimated Maximum Incentive Amount		$17,183	$18,382	$19,980
Domain 3: Potentially Preventable Complications (PPCs)				
Planned Reporting Period: 1 or 2			2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 3- Estimated Maximum Incentive Amount			$18,382	$19,980
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Medication Management				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 4- Estimated Maximum Incentive Amount		$17,183	$18,382	$19,980
Domain 5: Emergency Department				
Measurement period for report		1 (10/1 - 3/31)	1 (10/1 - 3/31)	1 (10/1 - 3/31)
Planned Reporting Period: 1 or 2		2 (4/1 - 9/30)	2 (4/1 - 9/30)	2 (4/1 - 9/30)
Domain 5- Estimated Maximum Incentive Amount		$17,183	$18,382	$19,980
Grand Total Payments – CAT 4	**$37,061**	**$85,916**	**$91,910**	**$99,902**

Section VI. RHP Participation Certifications

The following documents are certifications required by Section VI of the RHP Plan Template.

Section VII. Addendums

This section includes Addendums as required by the Program Funding & Mechanics Protocol, the RHP Planning Protocol, and the Regional Health Plan Template. Addendums are organized by the regional health plan section in which they appear.