Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP)

PLAN

March 11, 2013

Region 7 RHP

RHP Lead Contact:

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Section I. RHP Organization

REGIONAL HEALTH PARTNERSHIP 7 PARTICIPANT & STAKEHOLDER INFORMATION						
RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Anchoring Entity						
Healthcare District	*Not applicable*	10617309074000	Public	Central Health	Sarah Cook *Medicaid Waiver Director*	1111 E Cesar Chavez St Austin, Texas 78702 sarah.cook@centralhealth.net 512-978-8195
IGT Entities						
Independent School District		17460000643004		Austin Independent School District	Tracy Lunoff *Administrative Supervisor, Department of Comprehensive Health Services*	1111 W. 6th Street Austin, Texas 78703 tracy.lunoff@austinisd.org 512-414-9778
Local Mental Health Authority	133542405	17415479090000		Austin/Travis County Integral Care	David Evans *CEO*	P. O. Box 3548 Austin, Texas 78764 david.evans@atcic.org 512-440-4030

Local Mental Health Authority		17427953322000		Bluebonnet Trails Community Services Center	Andrea Richardson *CEO*	1009 N. Georgetown Street Round Rock, Texas 78664 andrea.richardson@bbtrails.org 512-244-8305
County		17460016318017		Caldwell County	Rhoda Chavira *Director of Indigent Care*	110 South Main Street Lockhart, Texas 78644 Rhoda.chavira@co.caldwell.tx.us 512-398-1802
Healthcare District		10617309074000		Central Health	Trish Young Brown *CEO*	1111 E Cesar Chavez St Austin, Texas 78702 Trish.young@centralhealth.net 512-978-8000
City		17460000858210		City of Austin	Bob Corona *Chief of Staff*	P.O. Box 1088 Austin, Texas 78767-1088 bob.corona@austintexas.gov 512-972-5002
City		17460016342000		City of Lockhart	Lew White *Mayor*	P. O. Box 239 Lockhart, Texas 78644 lwhite@lockhart-tx.org 512-398-3461
City		17460016458007		City of Luling	Robert Berger *City Manager*	509 East Crockett Street Luling, Texas 78648 citymanager@cityofluling.net 830-875-2481

City		17460022381000		City of San Marcos	Steve Parker *Assistant City Manager*	630 E. Hopkins Street San Marcos, TX 78666 sparker@sanmarcostx.gov 512-393-8179
County		17460015443005		Fayette County	Edward Janecka *County Judge*	151 North Washington, Rm 301 La Grange, Texas 78945 ed.janecka@co.fayette.tx.us babette.skalka@co.fayette.tx.us 979-968-6469
Local Mental Health Authority		17428220176001		Hill Country MHDD Centers	David Weden *Development Officer*	819 Water Street, Suite 300 Kerrville, Texas 78028 dweden@hillcountry.org 830-258-5428
County		17460022415016		Hays County	Lon Shell *Chief of Staff*	111 East San Antonio Street San Marcos, Texas 78666 lon.shell@co.hays.tx.us 512-393-2217
Emergency Services Department		Pending. Federal Tax ID: 74-2879672		Wimberley Emergency Medical Department	Julia New *Board President*	Wimberley , Texas jrnew@gsmyc.org 512-738-6778
County		17460009867005		Lee County	Maxine Siegmund *County Auditor*	200 S. Main, Room 107 Giddings, Texas 78942 maxine.siegmund@co.lee.tx.us 979-542-3103

Hospital Authority		17417067349000		Smithville Hospital Authority	Noralene Corder *Interim COO*	800 East Highway 71 Smithville, Texas 78957 nlcorder@seton.org 512-237-5773
State Health Services Department		35375375371000		Texas Department of State Health Services	Olga Rodriguez *Director, Center for Program Coordination and Health Policy*	1100 West 49th Street Austin, Texas 78756 Olga.Rodriguez@dshs.state.tx.us 512-776-7181
Performing Providers						
Local Mental Health Authority	133542405	17415479090000	Non-State Public	Austin/Travis County Integral Care	Dawn Handley *Director of Services*	P. O. Box 3548 Austin, Texas 78764 Dawn.handley@atcic.org 512-440-4030
Local Health Department	201320302	17460000858210	Non-State Public	City of Austin Health and Human Services Department	Bob Corona *Chief of Staff*	P.O. Box 1088 Austin, Texas 78767 bob.corona@austintexas.gov 512-972-5002
Local Mental Health Authority	126844305	17427953322000	Non-State Public	Bluebonnet Trails Community Services Center	Andrea Richardson *CEO*	1009 N. Georgetown Street Round Rock, Texas 78664 andrea.richardson@bbtrails.org 512-244-8305

Private Hospital	121789503	17425754623015	Private	Central Texas Medical Center	Ann Berghammer-Miller *Director of Managed Care*	1301 Wonder World Drive San Marcos, Texas 78666 Ann.Berghammermiller@ahss.org 512-753-3894
Atypical Provider	307459301	14611857542000	Non-State Public	Community Care Collaborative	Trish Young Brown	1111 E Cesar Chavez St Austin, Texas 78702 Trish.young@centralhealth.net 512-978-8000
Private Children's Hospital	186599001	17411096435036	Private	Dell Children's Medical Center	Sister Teresa George *President*	4900 Mueller Boulevard Austin, Texas 78723 512-324-0000
Local Mental Health Authority	133340307	17428220176001	Non-State Public	Hill Country MHDD Centers	David Weden *Development Officer*	819 Water Street, Suite 300 Kerrville, Texas 78028 dweden@hillcountry.org 830-258-5428
Private Hospital	176692501	17430198493001	Private	St. Mark's Medical Center	Dennis Boyd *CFO*	One St. Marks Place La Grange, Texas 78945 d.boyd@smmctx.org 979-242-2111
Public Hospital	137265806	17411096435000	Non-State Public	University Medical Center Brackenridge	Kate Henderson *VP & COO*	602 East 15th St. Austin, Texas 78702 kchenderson@seton.org 512-324-1940

UC Only Hospitals						
State Owned Public Hospital	021194801	33201136430000	Public	Austin State Hospital	Wilson M. Day *Deputy CFO*	1100 West 49th Street Austin, Texas 78756
Private Hospital	094160102	17427818129000	Private	St David's Medical Center	Cindy Sexton *CFO*	98 San Jacinto Blvd, Ste 1800 Austin, Texas 78701 Cindy.Sexton@stdavids.com 512-482-4162
Private Hospital	094216102	17427818129000	Private	St David's North Austin Medical Center	Cindy Sexton *CFO*	98 San Jacinto Blvd, Ste 1800 Austin, Texas 78701 Cindy.Sexton@stdavids.com 512-482-4162
Private Hospital	112717702	17427818129000	Private	St David's South Austin Medical Center	Cindy Sexton *CFO*	98 San Jacinto Blvd, Ste 1800 Austin, Texas 78701 Cindy.Sexton@stdavids.com 512-482-4162
Private Hospital	094153604	17411096435079	Private	Seton Edgar B. Davis	Neal Kelley *COO*	130 Hays Street Luling, Texas 78648 nkelley@seton.org csaucedo@seton.org 830-875-7000

Private Hospital	135225404	17411096435031	Private	Seton Medical Center	Charlotte Thrasher *VP & COO*	1201 West 38th Street Austin, Texas 78705 cthrasher@seton.org csaucedo@seton.org 512-324-3039
Private Hospital	208013701	17411096435027	Private	Seton Medical Center Hays	Herb Dyer *VP & COO*	6001 Kyle Parkway Kyle, Texas 78640 hdyer@seton.org csaucedo@seton.org 512-324-5055
Private Hospital	158980601	17411096435026	Private	Seton Northwest Medical Center	Scott Fuller *VP & COO*	11113 Research Blvd Austin, Texas 78759 sfuller@seton.org csaucedo@seton.org 512-324-6900
Private Hospital	094382101	17411096435006	Private	Seton Shoal Creek	Alan Isaacson *VP & COO*	3501 Mills Ave Austin, Texas 78731 aisaacson@seton.org csaucedo@seton.org 512-324-2041
Public Hospital	286326801	17411096435035	Non-State Public	Seton Smithville Hospital	Noralene Corder *Interim COO*	800 East Highway 71 Smithville, Texas 78957 nlcorder@seton.org csaucedo@seton.org 512-237-5773

Private Hospital	158977201	17411096435100	Private	Seton Southwest Medical Center	Mary Faria *VP & COO*	7900 FM 1826 Austin, Texas 78737 mfaria@seton.org csaucedo@seton.org 512-324-9041

Other Stakeholders						
County				Travis County	Sherri Fleming *County Executive*	502 East Highland Mall Blvd Austin, Texas 78752 Sherri.fleming@co.travis.tx.us 512-854-4101
County Medical Association				Bastrop-Lee Medical Society	Dr. Pompeyo C. Chavez *President*	3101 Highway 71 E Ste 101 Bastrop, Texas 78602 512-304-0341
County Medical Association				Hays-Caldwell-Blanco Medical Society	Dr. John E. Lee Sang *President*	1301 Wonder World Drive San Marcos, Texas 78666 joleesang@yahoo.com 512-753-3513
County Medical Association				Travis County Medical Society	Dr. R. Y. Declan Fleming *President*	4300 North Lamar P. O. Box 4679 Austin, Texas 78765 512-206-1146
County Medical Association				Colorado-Fayette Medical Society	Dr. Charles R. Gobert *President*	2540 Hwy 71 S Ste 100 Columbus, Texas 78934 979-733-0238
Regional Public Health Director				Department of State Health Services	Dr. Lisa Cornelius *Regional Medical Director, Health Services Region 7*	2408 South 37th Street Temple, Texas 76504 Lisa.cornelius@dshs.state.tx.us 254-778-6744

Federally Qualified Health Center				Community Health Centers of South Central Texas	Henry F. Salas *CEO*	111 South Laurel Avenue Luling, Texas 78648 830-875-6399
Federally Qualified Health Center				Communicare	Paul Nguyen *CEO*	3066 East Commerce Street San Antonio, Texas 78220 210-233-7070
Federally Qualified Health Center				Central Texas Community Health Centers d/b/a CommUnityCare	Leslee Froehlich *Interim CEO*	15 Waller Street, 5th Floor Austin, Texas 78702 Leslee.froehlich@communitycaretx.org 512-978-9000
Federally Qualified Health Center				Lone Star Circle of Care	Pete Perialas *CEO*	1500 West University Ave. Georgetown, Texas 78628 pperialas@lscctx.org 512-686-0152
Federally Qualified Health Center				People's Community Clinic	Regina Rogoff *CEO*	2909 North I. H. 35 Austin, Texas 78722 reginar@austinpcc.org 512-708-3121
Federally Qualified Health Center				Tejas Health Care	Jana McDermott *Executive Director*	753 East Travis Street La Grange, Texas 78945 979-968-2000

Private Safety Net Provider				El Buen Samaritano	Victor Azios *Executive Director*	7000 Woodhue Drive Austin, Texas 78745 vazios@elbuen.org 512-439-0700
Private Safety Net Provider				Planned Parenthood Of Greater Texas	Sarah Wheat *VP for Community Affairs*	201 East Ben White Blvd. Bldg B Austin, Texas 78704 sarah.wheat@ppaustin.org 512-275-0171
Private Safety Net Provider				Project Access	Cliff Ames *Director*	4300 North Lamar P. O. Box 4679 Austin, Texas 78765 cames@tcms.org 512-206-1165
Private Safety Net Provider				Volunteer Clinic	Marci Roe *Executive Director*	4215 Medical Parkway Austin, Texas 78756 Info@volclinic.org 512-459-6002
Service Agency				Any Baby Can	Margi Preston *Executive Director*	1121 East 7th Street Austin, Texas 78702 MargiP@anybabycan.org 512-454-3743
Service Agency				Austin Recovery	Craig Ross *Director of Outpatient Programs*	8402 Cross Park Drive Austin, Texas 78754 cross@austinrecovery.org 512-697-8500

Service Agency				Family ElderCare	Angela Atwood *CEO*	1700 Rutherford Lane Austin, Texas 78754 aatwood@familyeldercare.org (512) 450-0844
Service Agency				Austin/ Travis County Emergency Medical Services	Keith Simpson *Quality & Compliance Manager*	15 Waller Street Austin, TX 78702 Keith.simpson@austintexas.gov 512-972-7200
Service Agency				Latino Healthcare Forum	Michael Candelas *Interim CEO*	701 Brazos St., Suite 500 Austin, Texas 78701 Michael@latinohealthcareforum.org 855-873-5578
Association/ Advocacy Group				ECHO: Ending Community Homelessness	Ann Howard *CEO*	100 N IH 35, Ste. 1003 Austin, Texas 78701 annhoward@austinecho.org Phone: (512) 963-7630
Association/ Advocacy Group				Texans Care for Children	Clayton Travis	811 Trinity St, Suite A Austin, Texas 78701 ctravis@txchildren.org 512-473-2274
Association/ Advocacy Group				Texas Association of Charitable Clinics	Jody Hopkins	P.O. Box 684127 Austin, Texas 78768 jhopkins@tx-lsacc.org 512-777-8929

Association/ Advocacy Group				Texas Non-Profit Hospice Alliance	Kirsti Krejs *President/CEO*	P.O. Box 50266 Austin, Texas 78763 kirsti.krejs@tnpha.org 832-523-4652
Foundation				St David's Foundation	Bobbie Barker *VP of Grants & Community Programs*	811 Barton Springs Road Austin, Texas 78704 bbarker@stdavidsfoundation.org 512-879-6600
Foundation				Sims Foundation	Maria Maddocks *Office and Finance Manager*	mmaddocks@simsfoundation.org

Section II. Executive Overview of RHP Plan

Region 7 is pleased to present the attached Regional Healthcare Partnership (RHP) Plan for the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. Region 7 is diverse in many aspects: both rural and urban, with areas that contain developed infrastructure and other areas with very limited infrastructure. Region 7 stakeholders embrace the opportunity provide through the waiver to improve access to care substantially for seriously underserved populations by creating infrastructure where none currently exists while also strengthening care delivery and coordination in areas that have more robust services.

RHP Goals / Vision

Region 7 stakeholders envision creating a coordinated healthcare system where **Good health is achievable for all people in Region 7**.

In support of this vision, Region 7 stakeholders have identified the following goals for delivery system transformation during the 5-year waiver period:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 population to include the right mix of providers, better data, and service delivery locations that are more accessible.
2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
3. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
4. Bolster individual and population health by improving chronic disease management.
5. Support prevention education and healthy lifestyles to improve population health.
6. Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.
7. Improve the patient experience of care by increasing the quality of care and patient safety.

Existing RHP Healthcare Environment

Region 7 includes six counties in Central Texas with approximately 1.3 million residents. Together, Travis and Hays Counties account for almost 90% of the population within the region. The remaining four counties (Bastrop, Caldwell, Fayette, and Lee) are primarily rural with relatively small populations. Approximately 285,000 (22%) Region 7 residents are uninsured, and nearly 150,000 (12%) residents, mostly children, rely on Medicaid.

The majority of healthcare infrastructure in Region 7 is concentrated in Travis County. Counties outside Travis experience shortages across a number of critical healthcare provider categories. All Region 7 counties are designated in whole or in part as Health Professional Shortage Areas and Medically Underserved Areas. Transportation access for healthcare services has been identified as a challenge for people in rural areas as well as low-income populations in urban areas.

The population for all counties in Region 7 is projected to increase throughout the waiver period, with Hays and Bastrop counties each expected to grow more than 30% between 2000 and 2016. Population growth will further strain already limited healthcare resources.

The region is projected to become increasingly diverse through 2016, which will exacerbate existing racial and ethnic disparities across many health conditions. An aging population will also contribute to additional demand for specialists as well as the need for resources to address chronic conditions.

Key Health Challenges

As noted, inadequate access to care (including primary care, specialty care, dental care, and behavioral health care) is a key health challenge for Region 7. The lack of providers and services available is particularly prevalent for specific populations, such as homeless, children, and elderly.

County representatives throughout Region 7 have identified chronic disease as one of the top health concerns for their residents. Cardiovascular disease, cancer, and pulmonary disease are among the leading causes of death in Region 7. Rates of adult diabetes in many Region 7 counties exceed Texas state averages and continue to rise. Obesity, physical inactivity, and tobacco use are critical factors contributing to chronic disease.

Patients with more than one chronic condition have a higher risk of potentially preventable hospitalizations, contribute to significantly higher healthcare costs, and are a greater challenge for coordination of care. Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition.

Behavioral health is also a key health concern among Region 7 stakeholders. Conservative estimates indicate that more than 20% of the region's population that is under 200% of the Federal Poverty Level with a severe mental illness is presently not receiving care. And of those who are receiving care, their needs are complex; approximately 70% of the population has additional complicating co-morbidities such as a substance use disorder, one or more chronic health conditions, or all three conditions.

People with co-morbidities, including multiple physical health conditions and co-occurring behavioral health concerns, must navigate a complicated and disconnected system of healthcare providers. Region 7 providers are recognizing the need to address these issues simultaneously. Achieving these improved outcomes will require integration of healthcare delivery that bridges and integrates currently separate physical and behavioral health delivery systems.

Inadequate access to care and a lack of care coordination also contribute to potentially preventable utilization of healthcare services. A 2011 analysis of emergency department (ED) visits by uninsured and underinsured patients in Travis County found that almost 50% of ED visits were for services that could have been provided in a primary care setting. An additional 6% required emergent care which potentially could have been prevented with appropriate ambulatory care.

In addition, adult residents of Region 7 have more than 8,500 potentially preventable inpatient hospitalizations per year for conditions such as bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and diabetes complications. Potentially preventable conditions requiring inpatient care contributed to over $1 billion in hospital charges between 2005 and 2010. Please refer to the Community Needs Assessment in Section III for additional detail regarding key health challenges facing Region 7.

Proposed DSRIP Projects to Realize the RHP Vision

Region 7 projects address a basic lack of infrastructure and services in rural areas as well as launching innovative projects focused on changing how we deliver care and decreasing costs. Across Region 7, participants are proposing upgrades to infrastructure that will significantly improve access to care to prevent the escalation of physical and mental health problems and/or utilization of inappropriate or expensive treatment settings such as criminal justice systems and emergency departments. The Community Care Collaborative, a newly launched accountable care-like integrated delivery system that will knit together Travis County's fragmented safety net healthcare delivery providers, will implement multiple infrastructure improvements such as expanding the medical home network and standardizing care delivery protocols among other innovative projects. Mobile services in multiple counties will improve access to

primary care and behavioral health services, bringing care to individuals who are not able to reach established clinic locations. Multiple projects will use telemedicine to fill the gap in psychiatric care, expanding care to individuals experiencing crisis and to providers needing support to care for complex patients.

System transformation and costs savings depend upon expanding access to the right care in the right setting. Region 7 addresses this goal in a number of ways: intervening at critical junctures, expanding access points, implementing new care delivery strategies and addressing both physical and behavioral health needs simultaneously. Mobile Crisis Outreach Teams and Assertive Community Treatment teams will focus on intervening with individuals experiencing behavioral health crisis and providing and/or connecting them with appropriate stabilization services in order to prevent them from entering the criminal justice system or inpatient psychiatric services. Expansion of primary care, urgent care, specialty care and integrated behavioral health services in every county will improve patient access to care while preventing utilization of more expensive services. This includes expansion of integrated care by adding behavioral health services to existing medical settings and adding medical care to existing behavioral clinics. School based behavioral health services in Fayette, Lee and Travis counties will help children and youth receive the care they need, minimize the strain on families and help keep kids in school, a long term strategy for improved health outcomes.

Region 7 is focused on improving patient experience by providing translation services in native languages, expanding navigation programs that help the seamless connection to services, providing patient centered comprehensive care and providing care at every stage of health, including palliative care.

High rates of chronic disease within Region 7 require the expansion of targeted chronic disease management programs. Multi-disciplinary teams intervening with obese children and their families and children with chronic disease address the complex needs of patients and help prevent the development of more serious complications. The care transitions program takes care to the patient in his/her home. This program focuses on individuals with multiple chronic conditions who are released from inpatient services and focuses on prevention of re-hospitalization.

In order to truly change course in Central Texas, it is essential to not only focus on intervention but also prevention and health promotion. Innovative strategies include deploying peer counselors who have successfully achieved health and wellness goals to encourage and support individuals with co-occurring behavioral health diagnoses and chronic conditions and/or unhealthy lifestyles to achieve their own health goals. These programs are particularly important given the early mortality of individuals with behavioral health issues. A tobacco cessation initiative targeting young adults addresses a top contributor to mortality/morbidity while intervening before tobacco induced chronic disease develops. Disease prevention and promotion of healthy lifestyles are essential to empowering individuals to improve their quality of life.

Region 7 is committed to continuous quality improvement to ensure that patients receive the care they need. Increasing access to data and continually analyzing data will enable providers to adjust interventions to better meet the needs of patients and reduce costs of care. The proposed projects will expand access to care, fill critical gaps, drive utilization away from emergency departments and the criminal justice system and improve the overall care and experience for patients.

Table of Category 1 & 2 Projects

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
Category 1: Infrastructure Development			
133542405.1.1 Pass 2 Mental Health First Aid and Suicide Prevention Austin Travis County Integral Care 133542405	Implement evidence-based Mental Health First Aid training program for primary care staff on how to identify, understand and respond to signs of mental illness and chemical dependency disorders and how to prevent suicide.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$1,967,599
133542405.1.2 Pass 2 Expand Specialty Behavioral Healthcare Prescriber Capacity Austin Travis County Integral Care 133542405	Employ additional practitioners with prescribing capability to provide outpatient medication management and care management services to maximize the ability of patients to remain stable and living within the community.	OD-1: Primary Care and Chronic Disease Management IT-1.18: Follow-up after hospitalization for mental illness	$10,699,341

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133542405.1.3 Pass 2 Introduce, Expand, or Enhance Telemedicine/Telehealth Austin Travis County Integral Care 133542405	Expand access to psychiatric evaluation and consultation and prescribing capabilities via telemedicine to Mobile Crisis Outreach Teams (MCOT) serving individuals experiencing psychiatric crisis. Maximizes the ability of MCOT to effectively and efficiently address patient needs and avoid need for more intensive and expensive services.	OD-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores	$1,400,743
126844305.1.1 Pass 1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Youth Counseling for Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Develop counseling and early intervention services that are delivered on school campuses in collaboration with the school districts in Fayette and Lee Counties.	OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$1,633,660

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
126844305.1.2 Pass 1 Development of behavioral health crisis stabilization services as alternatives to Hospitalization: Child Crisis Respite through Therapeutic Foster Care Bluebonnet Trails Community Services 126844305	Develop specialized Therapeutic Foster Care setting that can be used to intervene with youth in crisis and divert them from admission to a psychiatric hospital or juvenile justice facility.	OD-9: Right Care, Right Setting IT-9.1: Decrease in mental health admission and readmissions to criminal justice settings such as jails or prison	$3,274,447
126844305.1.3 Pass 2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Outpatient Substance Addiction Services for Adult and Youth in Bastrop, Caldwell, Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Add intensive outpatient and supportive counseling substance abuse services in Bastrop, Caldwell, Fayette and Lee Counties and ensure availability of services for individuals who are low-income and uninsured in order to improve health outcomes for persons who have limited access to behavioral health services.	OD-3 Potentially Preventable Re-Admissions-30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rate	$4,020,311

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
121789503.1.1 Pass 1 Expanding Primary Care capacity for low-income adult residents of Hays County, TX Central Texas Medical Center 121789503	Create the Central Texas Healthcare Collaborative Clinic to offer primary services to low-income adult residents of Hays County.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$11,677,250
307459301.1.1 Pass 3 The Community Care Collaborative's Implementation and enhancement of chronic disease management registry functionalities Community Care Collaborative 307459301	Implement and use chronic disease management registry (DMR) functionalities to systematically coordinate care for patients with two or more chronic diseases. The DMR will assist the provider care team to: ensure that these patients receive the proper care at the appropriate time; track progress and outcomes of care; identify the need for follow-up services; empower patients to take an active role in their treatment; and identify and target individuals with highest needs.	OD-1: Primary Care and Chronic Disease Management IT-1.4 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– diuretic IT-1.12 Diabetes care: Retinal eye exam (NQF 0055) IT-1.14 Diabetes care: Microalbumin/Nephropathy (NQF 0062)	$19,534,105

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.2 Pass 3 Expanded Primary Care Hours at Community-Based Outpatient Settings Community Care Collaborative 307459301	Expands access to routine and acute walk-in primary care by increasing operating hours of Community Collaborative Network Providers beyond Monday – Friday 8 to 5 and developing new capacity at the Southeast Hub. Provides access to care when patients need it most, reducing use of Emergency Departments for non-emergent issues.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$15,199,402
307459301.1.3 Pass 3 Expand Primary Care via Mobile Health Clinics Community Care Collaborative 307459301	Expands access to comprehensive primary care to geographically underserved areas of Travis County by deploying three mobile health clinics. Mobile clinic can serve as a primary care medical home as well as refer to other facilities with additional resources to support patient health outcomes.	OD-1: Primary Care and Chronic Disease Management IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) IT-1.8: Depression management : Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) IT-1.10: Diabetes care: HbA1c poor control (>9.0%) (NQF 0059)	$4,338,879

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.4 Pass 3 Expansion of Dental Services Community Care Collaborative 307459301	Expands availability of dental services low-income uninsured patients through addition of dentists and hygienists and expansion of dental service hours.	OD-7: Oral Health Outcomes 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	$12,898,784
307459301.1.5 Pass 3 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions Community Care Collaborative 307459301	Expands access to non-surgical musculoskeletal specialty services for uninsured, Medicaid and Medicare patients. Emphasis will be on physical therapy and rehabilitation for individuals not needing surgery but who have mobility issues or job related injuries.	OD-1: Primary Care and Chronic Disease Management IT-1.1: Third Next Available Appointment OD-10: Quality of Life/Functional Status IT-10.1: Quality of Life IT-10.7 Other Outcome Improvement Target : Improvement on OPTIMAL	$12,864,288

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.6 Pass 3 Expand Specialty Care Capacity for Gastroenterology Community Care Collaborative 307459301	Expands specialty care appointments at community based health centers for gastroenterology in order to reduce current 4 month wait time. Reducing wait times for visits will result in fewer visits to the emergency room and improved patient experience.	OD-1: Primary Care and Chronic Disease Management IT-1.1: Third Next Available Appointment IT-1-8: Depression Management - Screening and Treatment Plan for Clinical depression IT 1-20: Other Outcome Improvement Target – Annual Monitoring for Patients on Persistent Medications OD-12: Primary Care and Primary Prevention IT-12.3: Colorectal Cancer Screening (HEDIS 2012)	$11,364,114

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.7 Pass 3 Expand Specialty Care Capacity for Pulmonology Community Care Collaborative 307459301	Expands specialty care appointments for pulmonology for uninsured, Medicaid and Medicare patients. Services will be provided in community based health centers and reduce the current 4 month wait appointments resulting in fewer visits to the emergency room and improved patient experience.	OD-2: Potentially Preventable Admissions IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5	$10,268,806
307459301.1.8 Pass 3 Telepsychiatry in Federally Qualified Primary Health Clinics Community Care Collaborative 307459301	Expands access to psychiatric assessment and consultation through telemedicine for physicians and patients within community based health centers. Improves timely access to appropriate specialty services and improves patient health outcomes.	OD-1: Primary Care and Chronic Disease Management IT-1.9: Depression Management: Remission at 12 Months IT-1.20: Other Outcome Improvement Target - Anxiety Remission at 12 Months	$8,000,577

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
186599001.1.1 Pass 1 School Campus Counseling Dell Children's Medical Center 186599001	Expand campus based therapeutic behavioral health services, including access to telepsychiatry, to additional high school students and additional campuses, based on successful pilot program in Austin Independent School District.	OD-1 Primary Care and Chronic Disease Management IT-1.20 Other Outcome Improvement Target: Increase the number of patient visits for program participants aged 6 through 17 years of age with a diagnosis of major depressive disorder with an assessment for suicide risk.	$2,279,343
133340307.1.1 Pass 2 Hays County Mental Health Center Mobile Clinic Hill Country MHDD Centers 133340307	Deploy a Mobile Clinic to expand availability of comprehensive behavioral health services (including Case Management, Counseling, Pharmacological Management, Medication Training and Support, Psychiatric Rehabilitation, Skills Training, Engagement Activities, Supported Employment and Supported Housing) to individuals in outlying areas of Hays and Blanco counties.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$4,053,360

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.1 Pass 3 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Development of behavioral health crisis stabilization services as alternatives to hospitalization Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Creates a 24-7 Licensed Psychiatric Emergency Department for individuals experiencing psychiatric crises who need access to both emergency medical and psychiatric services, including assessment and treatment, followed by release or continued short term observation. Service will meet patient needs in a more appropriate setting and reduce use of Hospital Emergency Departments for psychiatric services.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health / Substance Abuse 30 day readmission rate	$16,326,906

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.2 Pass 3 Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or localities within non-HPSA counties which do not have access equal to the rest of the county: Expand Post Graduate Training for Psychiatric Specialties/Psychiatric Residency Programs Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Adds post-graduate training positions to increase the number of mental health professionals in the region, including psychiatrists, psycho-pharmacologists, psychosomatic and psychologists, thereby reducing wait times for appointments, easing the strain on emergency psychiatric care, and improving patient outcomes.	OD-1: Primary Care and Chronic Disease Management IT-1.18: Follow-Up After Hospitalization for Mental Illness	$8,180,595

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.3 Pass 3 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers: Psychiatric telemedicine for emergency services Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Expand access to provide 24/7 psychiatric consultations at the regional Level 1 Trauma Center emergency department by utilizing after-hours telemedicine services. Assess all patients presenting with primary or secondary mental health diagnosis, initiate treatment and/or refer appropriately to other services.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$5,767,094
137265806.1.4 Pass 3 Expand access to written and oral interpretation services: Language Services Resource Center Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Increase and improve language access to Spanish-speaking patients with Limited English Proficiencies (LEP) by increasing the number of qualified health care interpreters and creating a Language Resources Center that will coordinate and optimize the delivery of interpretation services.	OD-11: Addressing Health Disparities in Minority Populations IT-11.6: Other Outcome Improvement Target	$11,661,934

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.5 Pass 3 Clinical Cultural Competence: Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels: Culturally Competent Care Training Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Provide culturally competent care training, awareness and education to healthcare providers and staff at UMCB and four other Seton hospitals in Travis County in order that a diverse population of patients with access to health care delivered by culturally competent professionals who understand and respond effectively to the cultural needs.	OD-6: Patient Satisfaction IT- 6.1: Percent improvement over baseline of patient satisfaction scores	$6,821,304
176692501.1.1 Pass 1 Expanding Access to Specialty Care St. Mark's Medical Center 176692501	Expand access to specialty care physician services by recruiting additional physicians to provide OB/GYN, specialty care, and wound care services in Lee and Fayette Counties.	OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$256,130

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
Category 2: Program Innovation and Design			
133542405.2.1 Pass 1 Integrate Primary and Behavioral Health Care Services Austin Travis County Integral Care 133542405	Launch new outpatient behavioral health clinic with integrated medical care in the Dove Springs neighborhood in Austin to increase access to services for adults and children.	OD-1: Primary Care and Chronic Disease Management IT-1.18: Follow-Up After Hospitalization for Mental Illness OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$19,942,170
133542405.2.2 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting : Mobile Crisis Outreach Team Expansion Austin Travis County Integral Care 133542405	Expand Mobile Crisis Outreach Team crisis intervention to multiple locations to provide specialty behavioral health services and divert inpatient admissions, jail bookings and emergency department usage.	OD-3: Potentially Preventable Readmissions - 30 day Readmission Rates IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$19,826,460

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133542405.2.3 Pass 2 Hospital and Jail Alternative Project: Crisis Residential Program, Development of behavioral health crisis stabilization services as alternatives to hospitalization Austin Travis County Integral Care 133542405	Expand psychiatric crisis residential treatment services to provide short-term, community-based intensive psychiatric treatment for persons experiencing a psychiatric crisis and/or with severe functional impairment, thereby creating hospital and jail diversion treatment alternatives for individuals with co-occurring disorders.	OD-3: Potentially Preventable Re-Admissions IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$16,013,859
133542405.2.4 Pass 2 Community Behavior Support (CBS) Team Austin Travis County Integral Care 133542405	Create a Community Behavior Support (CBS) Team that provides medically complex treatment including crisis prevention, intervention and stabilization for people who have a co-occurring diagnosis of a developmental disability (DD) and mental illness (MI) or mental health disorder.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$4,315,618

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133542405.2.5 Pass 2 Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults Austin Travis County Integral Care 133542405	Implement multi-component, evidence-based health promotion programming in chronic disease management for adults with SMI to help individuals better understand their disease and how to manage it, and in the longer term, see reductions in negative health indicators (weight, cholesterol, etc.).	OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores for patient's overall health/functional status using the CG-CAHPS Survey.	$6,612,177
133542405.2.6 Pass 2 Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services Austin Travis County Integral Care 133542405	Implement a multi-component, evidence-based peer support training curriculum to expand the role of mental health peer supports to help peers living with Serious Mental Illness to adopt whole health life styles (e.g., tobacco-free, good nutrition, regular exercise).	OD-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores	$1,190,380

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
126844305.2.1 Pass 1 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above: Transitional Housing Guided by Peer Support Bluebonnet Trails Community Services 126844305	Implement a transitional housing project grounded in best practice recovery principles and guided by peer support in order to improve self-management and independent living for people exiting crisis services.	OD-3: Potentially Preventable Re-admissions - 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$2,614,016
126844305.2.2 Pass 2 Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD); for Bastrop, Caldwell, Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Provide Assertive Community Treatment (ACT) services for individuals with IDD who are experiencing crisis and/or life transitions in order to divert people with IDD from higher cost, institutional placement and into local resources. Provide specialized consultation to attending physicians.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$1,038,183

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
126844305.2.3 Pass 2 Services for Justice-Involved Youth and Adults: Bastrop, Caldwell, Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Decrease incarceration of individuals with behavioral health diagnoses who commit minor offenses. Collaborate with juvenile and adult Court systems in Bastrop, Fayette, Caldwell and Lee counties to provide screening, assessment and diversion recommendations prior to long-term incarceration.	OD-9: Right Care, Right Setting IT- 9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	$914,764
126844305.2.4 Pass 2 Design, implement, and evaluate project that provides integrated primary and behavioral health care services: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County Bluebonnet Trails Community Services 126844305	Partner with Community Health Centers of South Central Texas (CHCSCT) to establish and jointly operate a primary care / behavioral health care clinic site in Lockhart, Texas.	OD-1: Primary Care and Chronic Disease Management IT-1.8: Depression management: screening and treatment plan for clinical depression IT-1.9: Depression management: depression remission at twelve months	$17,994,377

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
201320302.2.1 Pass 1 Provide ACT Model for Participants of HF PSH City of Austin Health & Human Services Department 201320302	Provide additional supports to recently housed persons with co-occurring psychiatric, substance abuse, and medical diagnoses through an Assertive Community Treatment model implemented at existing non-profit housing units.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$874,500
201320302.2.2 Pass 1 Expansion of Community Diabetes Project City of Austin Health & Human Services Department 201320302	Train and deploy community health workers to deliver culturally appropriate chronic disease self-management education to Hispanic and African-American patients.	OD-10: Quality Of Life/Functional Status IT-10.1: Quality of Life	$1,750,000
201320302.2.3 Pass 1 Prevention and Cessation Program for 18-24 years olds in Travis County City of Austin Health & Human Services Department 201320302	This project is an evidence-based comprehensive tobacco prevention and cessation intervention to reduce tobacco use among the 18-24 year old population in Travis County.	OD-12: Primary Care and Primary Prevention IT-12.6: Other Outcome Improvement Target: Adult Current Smoking Prevalence.	$2,390,000

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
201320302.2.4 Pass 2 Prenatal, Post-Natal Program City of Austin Health & Human Services Department 201320302	The Prenatal & Postnatal Program will use Community Health Workers (CHWs) to improve birth and twelve-month postnatal outcomes with an emphasis on African American women in the community through increased access to pre- and post-natal care and health literacy.	OD-8: Perinatal Outcomes IT-8.2 Percentage of Low Birthweight births	$2,390,669
201320302.2.5 Pass 2 Healthy Families Program Expansion City of Austin Health & Human Services Department 201320302	Provide home visiting and family support services based on the evidence-based Healthy Families America model to improve families' access to preventive services including establishing a medical home, immunizations, well-child checks, developmental assessments, parenting education, and home and personal safety practices such as car seats. Program targets family at risk for child abuse.	OD-11: Addressing Health Disparities in Minority Populations IT-11.2: Improvement in disparate health outcomes for target population including identification of the disparity gap IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity	$1,190,000

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
201320302.2.6 Pass 2 Adult Immunizations to High Risk Populations City of Austin Health & Human Services Department 201320302	Increase the number of vaccinations available to six targeted high-risk populations with complex needs who are at risk for vaccine preventable diseases.	OD- 11: Addressing Health Disparities in Minority Populations IT-11.1: Improvement in Clinical Indicator in identified disparity group	$7,626,891
307459301.2.1 Pass 3 The Community Care Collaborative's Patient-Centered Medical Home Community Care Collaborative 307459301	The goal of this project is to establish or enhance shared care standards, data exchange protocols, and organizational approaches to care that will allow for a coordinated, collaborative provider network to improve patient health management.	OD-1: Primary Care and Chronic Disease Management IT-1.1: Third Next Available Appointment IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012): angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) IT-1.13 Diabetes care Foot exam (NQF 0056) OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$18,003,925

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.2.2 Pass 3 Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions Community Care Collaborative 307459301	Research, design and implement Chronic Care Management models to be used across the Community Care Collaborative network of safety net providers to manage 18,000 patients with multiple chronic conditions.	OD-1: Primary Care and Chronic Disease Management IT-1.6: Cholesterol management for patients with cardiovascular conditions IT-1.11: Diabetes Care: Blood Pressure Control (<140/90 mm/Hg) OD-10: Quality of Life/Functional Status	$18,710,458
307459301.2.3 Pass 3 Integrated Behavioral Health Intervention for Chronic Disease Patients Community Care Collaborative 307459301	Identifies and refers patients with co-occurring chronic diseases and behavioral health issues to on site behavioral health counseling services designed to improve daily well-being and support treatment compliance.	OD-1: Primary Care and Chronic Disease Management IT - 1.9: Depression management: Depression Remission at Twelve Months (NQF# 0710) IT-1.10: Diabetes Care: HbA1c Poor Control (>9.0%)	$9,728,463

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.2.4 Pass 3 Sexually Transmitted Disease Screening, Treatment, and Prevention Community Care Collaborative 307459301	Expand access to screenings and treatment for sexually transmitted diseases, and HIV tests and referrals for high risk low-income and Medicaid eligible individuals who lack access to these critically needed exams. Outreach and education efforts will target those most at risk for exposure/ infection.	OD-11 Addressing Health Disparities in Minority Populations IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Gonorrhea IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Chlamydia IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – HIV	$3,372,979

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.2.5 Pass 3 Adolescent and Young Adult Pregnancy Prevention Community Care Collaborative 307459301	Provide long-acting reversible contraception, as medically appropriate, to low-income, uninsured adolescents and young adult females who currently do not have access to these services to reduce unintended pregnancies, reduce public health costs and promote population health.	OD-1: Primary Care and Chronic Disease Management IT-1.20: Other Outcome Improvement Target: Reduction of Pregnancy Rate among Females at risk for unintended pregnancy	$4,674,285
307459301.2.6 Pass 3 Community Health Paramedic Navigation Program Community Care Collaborative 307459301	Expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to low-income Travis County residents with multiple chronic conditions and frequent recent Emergency Department (ED) utilization.	OD-9: Right Care, Right Setting IT-9.2: ED Appropriate Utilization	$6,689,613

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
186599001.2.1 Pass 1 Family and Child Obesity Dell Children's Medical Center 186599001	Expand multi-disciplinary weight management treatment team for obese children and their families and provide individual, family and community support and ancillary services to encourage and maintain positive health behaviors.	OD-9: Right Care, Right Setting IT-9.4: Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	$9,479,798
186599001.2.2 Pass 1 Chronic Care Management – Pediatrics Dell Children's Medical Center 186599001	Deliver comprehensive medical care with accompanying psychosocial supports using team approach for children with complex chronic disease and their families.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$14,414,008
133340307.2.1 Pass 1 Hays County Mental Health Center Integrated Care Hill Country MHDD Centers 133340307	Integrate primary care into the Hays County Mental Health Clinic as a means to address potentially preventable admissions of Diabetes and Hypertension with a secondary diagnosis of mental illness for individuals with severe and persistent mental illness.	OD-10: Quality Of Life/Functional Status IT-10.1: Quality of Life - SF-12	$3,131,599

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.2 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting Hays County Mental Health/Intellectual & Developmental Disability Crisis Center Hill Country MHDD Centers 133340307	Provide temporary emergency respite to reduce the recurrence of the crisis in the future to individuals with dual diagnosis of Intellectual & Developmental Disability and Mental Health issues who are in crisis.	OD-10: Quality of Life/Functional Status IT-10.7: Other Outcome Improvement Target - Supports Intensity Scale	$2,094,226
133340307.2.3 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder Hill Country MHDD Centers 133340307	Identify and train licensed chemical dependency counselors in the provision of co-occurring psychiatric and substance use disorder services such as substance abuse services, cognitive processing therapy, psychosocial rehabilitation and wrap around services to help the individual with co-occurring diagnosis.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living – DLA-20	$878,668

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.4 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care Hill Country MHDD Centers 133340307	Offer Mental Health First Aid training and Trauma Informed Care training to schools, law enforcement, hospitals, physicians, and community organizations to help professionals understand the role trauma plays in individual lives and the early warning signs of mental health issues.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,120,842
133340307.2.5 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health Services Hill Country MHDD Centers 133340307	Expand Veteran Peer Coordinators program in Hays County to recruit additional peer volunteers and develop a drop-in center in order to connect veterans to needed community resources and make medical and behavioral referrals. This project will also include provision of clinical behavioral health services from clinicians who have been trained in cultural competency for the military environment.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$2,947,902

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.6 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Children's Mental Health Crisis Center Hill Country MHDD Centers 133340307	Establish the Children's Mental Health Crisis Respite Center for children with mental health issues in order to provide temporary emergency respite and by organizing more appropriate resources in order to reduce psychiatric hospital utilization by children in crisis.	OD-10: Quality of Life/Functional Status IT-10.7: Other Outcome Improvement Target: Traumatic Events Screening Inventory	$3,242,689
133340307.2.7 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Children's Trauma Informed Care Hill Country MHDD Centers 133340307	Design and establish a Child Focused Trauma Informed Care program throughout Hays County to offer evidence based trauma counseling such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help children deal with trauma they have experienced.	OD-10: Quality of Life/Functional Status IT-10.7: Other Outcome Improvement Target: Traumatic Events Screening Inventory	$2,358,318

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.8 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Mental Health Courts Hill Country MHDD Centers 133340307	Establish Mental Health Courts in order to increase treatment compliance of individuals with mental illness who are identified as having frequent utilization of Emergency Departments, the criminal justice system, and/or psychiatric inpatient services. Case Managers will deliver and/or connect appropriate community-based interventions including psychosocial rehabilitation, Cognitive Behavioral Therapy, Cognitive Processing Therapy, supported employment, transportation, peer support, and other services.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,870,853

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.9 Pass 2 Recruit, train and support consumers of mental health services to provide peer support services: Adult Whole Health Peer Support Hill Country MHDD Centers 133340307	Expand peer services at 7 mental health clinics. Deploy consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful to provide behavioral health services targeting individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity. Improve Daily Living Activities and health outcomes and decrease utilization of Emergency Departments.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,644,488

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.10 Pass 2 Recruit, train and support consumers of mental health services to provide peer support services: Adolescent Whole Health Peer Support Hill Country MHDD Centers 133340307	Develop an Adolescent Whole Health Peer Support Network using consumers of adolescent mental health services who have made substantial progress in managing their own illness and recovering a successful life to assist other adolescents with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity. Improve Daily Living Activities and health outcomes and decrease utilization of Emergency Departments.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,233,364

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.11 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Family Partner Program Hill Country MHDD Centers 133340307	Expand Family Partner Services to provide support to primary caregivers who have children with mental illness or behavioral issues. Provide peer mentoring and support including modeling self-advocacy skills, providing information, referral and non-clinical skills training, and assisting in the identification of natural/non-traditional and community support systems.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$3,168,991
133340307.2.12 Pass 2 Hays County Virtual Psychiatric and Clinical Guidance Hill Country MHDD Centers 133340307	Provide 24 hour a day 7 day a week Psychiatric Consultation to Primary Care Providers and hospitals within Hays County to improve care and connection to services for individuals who present with behavioral health conditions.	OD-12: Primary Care and Primary Prevention IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9) IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE & AUDIT)	$2,506,310

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.1 Pass 1 OB Navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	The project would improve access to pre- and post-natal care for uninsured Hispanic women with limited English proficiency through comprehensive, effective patient navigation services.	OD- 8 Perinatal Outcomes IT-8.1 Timeliness of Prenatal/Postnatal Care IT-8.9 Other Outcome Improvement Target	$1,958,200
137265806.2.2 Pass 2 Women's Oncology Care Screening Seton Healthcare Family: University Medical Center at Brackenridge 137265806	This project expands access to timely breast and cervical cancer screening via a mobile unit for uninsured and underinsured women in Travis County, who, without this expansion likely would not receive these life-saving services.	OD- 12 Primary Care and Primary Prevention IT-12.6-Other Outcome Improvement Target	$4,569,448

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.3 Pass 3 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Substance abuse navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Develop a care transition program for un- and underinsured patients who are at risk for a Substance Use Disorder. Direct individuals toward early intervention/ treatment opportunities and education in order to identify and provide treatment and educational options to patients at risk for SUD.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$5,593,480
137265806.2.4 Pass 3 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Behavioral Health Assessment and Resource Navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	The Behavioral Health Assessment and Resource Navigation project creates a program to support uninsured individuals needing behavioral health care by providing free behavioral health assessments and referral to community treatment providers.	OD-3: Potentially Preventable Re-Admissions 30-day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30-day Readmission Rate	$5,551,659

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.5 Pass 3 Care Transitions Intervention Seton Healthcare Family: University Medical Center at Brackenridge 137265806	This project creates a multi-disciplinary team that monitors and coordinates the care of patients with chronic disease immediately following discharge from hospital to home, and from home to primary care. This project is expected to optimize the patient's recovery and avoid readmission.	OD-9: Right Care, Right Setting IT-9.2 ED: appropriate utilization	$14,902,218
137265806.2.6 Pass 3 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Chronic care management for adults Seton Healthcare Family: University Medical Center at Brackenridge 137265806	This is a chronic care management program that provides direct health care and care coordination for adults who have been seriously injured and to those who have experienced a serious illness due to multiple chronic conditions. Project will prevent avoidable hospitalizations and inappropriate utilization of the emergency room.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$16,645,628

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.7 Pass 3 Use of Palliative Care Programs: Implement a Palliative Care Program to address patients with end of life decisions and care needs Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Creates a new palliative care (PC) program devoted to providing palliative care to patients through a serious illness that may be chronic, terminal or acutely devastating. Services will be provided to inpatients and outpatients at UMCB, primary care clinics, patient homes and at specialty settings such as oncology, congestive heart failure and heart transplant clinics.	OD-13: Palliative Care IT-13.1: Pain Assessment (NQF 1637) IT-13.2: Treatment Preferences (NQF 1641) IT-13.6 Other Improvement Target: Increase the percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of ICU admission.	$6,340,905
137265806.2.8 Pass 3 Women's Oncology Care Navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Expands existing patient navigation services that connect women with breast/gynecologic cancer diagnoses to treatment and/or survivorship support services. Expands support to survivors of breast/gynecologic cancers.	OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$4,611,402

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.9 Pass 3 Reduction in 30 Day Hospital Readmission Rates: Adult diabetes inpatient chronic care management Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Develop an Interdisciplinary Diabetes Team to address the clinical, safety, and psychosocial needs of inpatients with diabetes while preparing for a successful discharge. Ensure that patients are evaluated and given customized tools for managing their disease post-discharge.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.3: Diabetes 30 day readmission rate	$10,919,329

Section III. Community Needs Assessment

This assessment provides an overview of Region 7 demographics, insurance coverage, healthcare infrastructure, key health challenges, and expected changes during the waiver period.

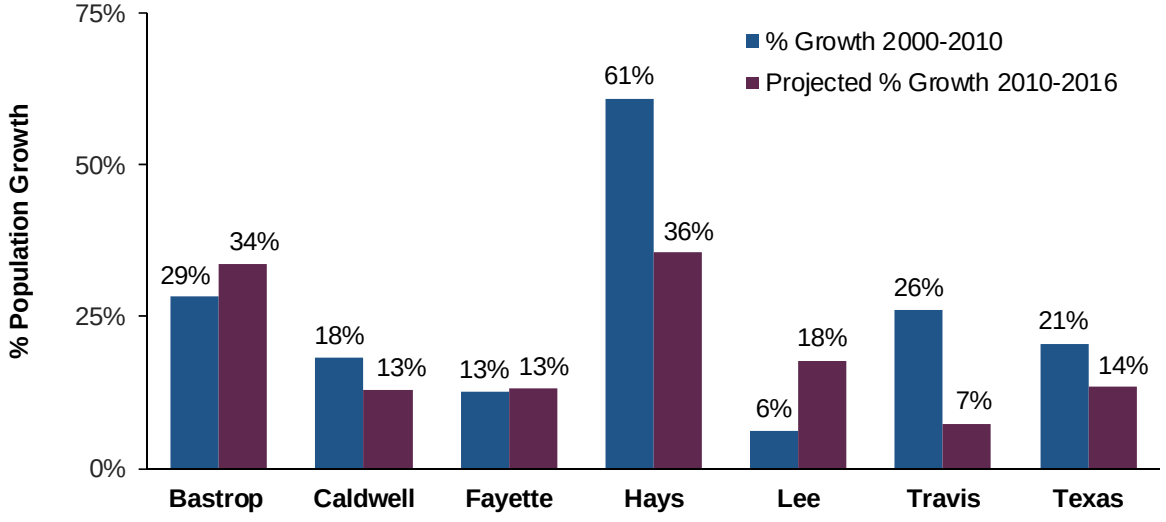
The community needs assessment incorporates publicly available information from resources such as the United States Census and the Texas Department of State Health Services (DSHS), as well as information from available regional reports and county-specific needs assessments. Additionally, Central Health distributed a qualitative questionnaire to health care stakeholders in each of the six counties and used this input to validate or expand upon the quantitative data. The end notes in Appendix A list the sources used within the Community Needs Assessment.

Information from all sources informed the development of the list of community needs. Please refer to the accompanying table for a summary of community needs addressed through the RHP plan.

A. Demographics

The total population of Region 7 is approximately 1.3 million residents - 5.3% of the total state population in 2010. Travis County includes Austin, the most densely populated city within Region 7. Together, Travis and Hays Counties account for almost 90% of the population within the region. The remaining four counties (Bastrop, Caldwell, Fayette, and Lee) are primarily rural with relatively small populations.[i] The populations in all counties are expected to grow during the course of the waiver, with Hays and Bastrop counties each expected to grow more than 30% between 2000 and 2016 (see Figure 1).[ii]

Figure 1. Region 7 Total Population and % Growth by County, 2000-2016

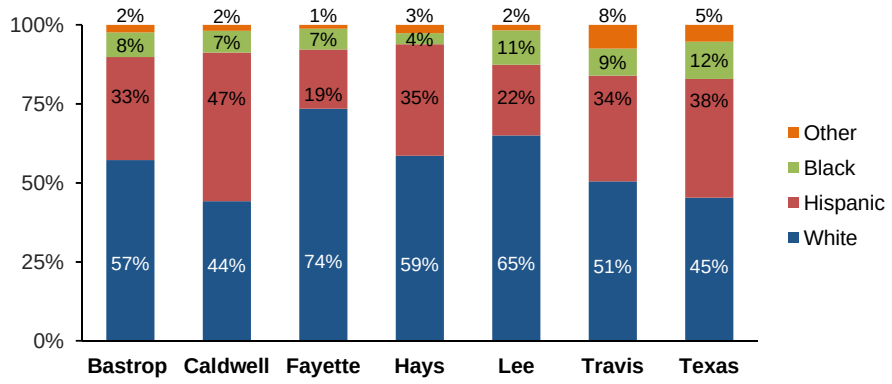


	Bastrop	Caldwell	Fayette	Hays	Lee	Travis	Texas
2000 Population	57,733	32,194	21,804	97,589	15,657	812,280	20,851,820
2010 Population	74,171	38,066	24,554	157,107	16,612	1,024,266	25,145,561
2016 Projected	99,100	42,967	27,775	213,202	19,568	1,100,447	28,568,732

Racial and Ethnic Composition

The racial and ethnic composition of Region 7 varies widely by county (see Figure 2). Fayette County has the largest percentage of White residents (74%). Caldwell County has the largest proportion of residents who are Hispanic (47%). Lee County has the largest proportion of Blacks (11%). Travis County has the greatest proportion of other races (8%) which includes Asians (5.8%).

Figure 2. Region 7 Race/Ethnicity Distribution by County, 2010

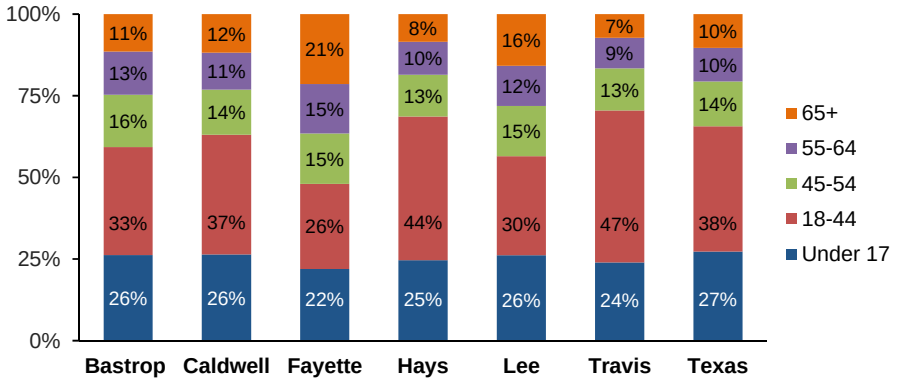


The percent of people over age 5 who speak a language other than English at home varies widely across the region, from 18.3% in Fayette County to approximately 32% in Travis and Caldwell Counties.[iii]

Age Composition

Age distribution also varies widely across Region 7 counties, most notably among those between 18 and 44 and those over 65 (see Figure 3). Travis County has the highest proportion of residents between 18 and 44 (47%) and the lowest proportion of residents over 65 (7%). Fayette County has the largest proportion of individuals over age 65 (21%).[iv]

Figure 3. Region 7 Age Distribution by County, 2010



Education and Employment

Educational attainment varies across Region 7 counties (see Table 1). Hays and Travis County residents were more likely to have achieved higher education levels. Caldwell County had the lowest portion of the population that completed high school.[v] Higher levels of education are associated with better health outcomes.[vi] Government, higher and primary education, and healthcare sectors employ the majority of Region 7 residents. In addition, Travis and Hays Counties also contain technology industries, and rural counties in the region contain manufacturing and transportation.[vii] Caldwell County has the highest unemployment rate (8.5%) in Region 7. Fayette and Lee Counties had the lowest percentages of residents who were unemployed (see Table 1).[viii]

Table 1. Region 7 Educational Attainment (2006-2010) and Unemployment by County (2011)

	Bastrop	Caldwell	Fayette	Hays	Lee	Travis	Texas
Educational Attainment (Ages 25 and older)							
High School Graduate	81%	76%	79%	88%	79%	86%	80%
Bachelor's or Higher	18%	14%	18%	35%	15%	44%	26%
Unemployment Rate	7.8%	8.5%	5.8%	6.7%	5.9%	6.6%	7.9%

Poverty Status

The proportion of Region 7 residents living under 100% of the federal poverty level (FPL) ranges from 11% (Fayette) to 20% (Caldwell). In many counties, more than one-third of the population lives below 200% FPL.[ix] The annual point-in-time analysis indicated that 2,244 people experienced homelessness in Travis County in 2012, and over 11,000 people sought support related to homelessness prevention.[x]

Table 2. Region 7 Percent of Individuals Living Below Federal Poverty Level, 2006-2010

	Bastrop	Caldwell	Fayette	Hays	Lee	Travis	Texas
Below 100% FPL	14.1%	19.6%	11.0%	16.4%	10.8%	16.2%	16.8%
Below 200% FPL	36.3%	41.6%	33.6%	30.9%	29.3%	33.8%	37.8%

Expected Changes and Implications

While most of Region 7's population is concentrated in Travis County, where Austin is located, the surrounding counties of Hays and Bastrop are growing rapidly. Hays County was the fastest growing county in the region from 2000 to 2010, growing 61% during the decade and is expected to grow an additional 36% through 2016. Bastrop County is the second fastest growing county with a 29% growth rate between 2000 and 2010 and is projected to grow an additional 34% from 2010 to 2016.[xi,xii]

Region 7 is projected to become increasingly diverse through 2016, with the greatest increases attributed to Hispanics (increasing from 34% of the region in 2010 to approximately 41% in 2016). Hispanics typically have higher rates of diabetes, obesity, and physical inactivity compared with Whites. In addition, Hispanic mothers also have higher rates of teen births and lower rates of timely prenatal care than White mothers. Conversely, mortality rates for cardiovascular disease, cancer, and HIV/AIDS tend to be lower among Hispanics. A more diverse population will continue to increase the need for culturally sensitive and linguistically accessible prevention and care.

At the same time, the population throughout Region 7 is aging. Hays County has the largest projected growth among seniors age 65+ as well as among pre-seniors ages 55 to 64.[xiii] Rates of diabetes and other chronic diseases tend to become more prevalent with advancing age, and an older population will contribute to additional demand for healthcare resources.

B. Insurance Coverage

More than 285,000 Region 7 residents were uninsured in 2009. Bastrop, Caldwell, and Lee Counties have the highest rate of uninsured adults under age 65. Hays County has the smallest proportion of uninsured adults, yet 1 of 4 adults is uninsured.[xiv] Many Region 7 residents depend on public insurance programs for health coverage; nearly 150,000 residents, mostly children, rely on Medicaid.[xv] Due to Medicaid and the Children's Health Insurance Program (CHIP), children are more likely than adults to be insured. Despite the availability of these programs, 15-22% of children in Region 7 are uninsured. While seniors typically have access to Medicare, access to government coverage programs for adults ages 18 to 44 is limited. Within Travis County, Central Health operates the Medical Access Program (MAP) for residents at or below 100% of the federal poverty level and who are not eligible for other government health coverage programs. See Table 3 for a summary of health coverage by county.

Table 3. Region 7 Health Insurance Coverage by County

	Uninsured (2009)[xvi]	Medicaid (2011)[xvii]	CHIP (2011)[xviii]	Medicare (2010)[xix]	County Indigent Program (2011)[xx,xxi]	Commercial/ Other Insured (Calculated)[xxii]	Uninsured Children < 19 (2009)[16]	Uninsured Adults < 65 (2009)[16]
Bastrop	17,496	9,874	1,644	10,113	-	35,044	19%	31%
Caldwell	8,692	5,899	953	5,229	-	17,294	17%	31%
Fayette	4,441	2,365	461	5,505	-	11,782	19%	28%
Hays	31,005	13,656	2,588	15,429	600	93,828	16%	25%
Lee	3,655	1,849	351	2,519	-	8,238	22%	31%
Travis	220,429	115,698	15,833	87,515	21,055	563,735	15%	27%
Total	**285,718**	**149,342**	**21,830**	**126,310**	**21,655**	**729,921**	**16%**	**27%**

Expected Changes and Implications

Current Medicaid eligibility in Texas is limited primarily to children, pregnant women, and people with disabilities. The Affordable Care Act provides for the expansion of Medicaid to all legal residents living at or below 133% FPL, but it remains unclear whether Texas will participate in this expansion.

Under a moderate scenario to encourage public and private health insurance enrollment, recent analysis suggests that the number of uninsured in Region 7 counties could be reduced to approximately 155,000.[xxiii] Without an expansion of Medicaid, however, most currently uninsured, low-income Region 7 residents are expected to remain uninsured during the waiver period.

C. Healthcare Infrastructure

Areas and populations with limited access to healthcare services are designated by the federal government as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). All Region 7 counties are designated in whole or in part as HPSAs and MUAs.[xxiv] Even in Travis County, where the majority of the region's healthcare infrastructure is located, areas are designated HPSAs.

Healthcare Workforce

Across Texas, and also in Region 7, uneven geographic distribution of health providers hinders adequate access to care.[xxv] In Region 7's RHP, healthcare providers are concentrated in Travis County while other counties outside Travis experience shortages across a number of critical provider categories. Shortages in these other areas require non-Travis County residents to seek care in Travis County, effectively reducing provider availability for Travis County residents. Thus, the provider to population ratio in Travis County is effectively driven down and the entire region suffers from a deficit.

Table 4 below shows the population per provider ratios for Primary Care (PC) Physicians, Advanced Practice Nurses (APNs), Physician Assistants (PAs), Dentists, Behavioral Health (BH) Providers[xxvi], and Licensed Chemical Dependency Counselors (LCDCs) within each county.[xxvii] A higher ratio indicates more people per provider, reducing access to care.

Table 4. Region 7 Population per Provider Ratio by County, 2011

Provider Type	Population per Provider						
	Bastrop	Caldwell	Fayette	Hays	Lee	Travis	Texas
PC Physicians	2,912 ■ ↔	1,460 ■ ↓	1,602 ■ ↔	1,866 ■ ↔	4,592 ■ ↔	1,037 ■ ↔	1,438 ↔
APNs	5,279 ■ ↓	19,708 ■ ↑	4,272 ■ ↓	3,993 ■ ↓	6,123 ■ ↓	2,098 ■ ↓	3,029 ↓
PAs	10,557 ■ ↑	4,927 ■ ↓	- ■	8,175 ■ ↔	18,369 ■ ↔	3,745 ■ ↓	4,818 ↓
Dentists	4,022 ■ ↓	4,927 ■ ↓	2,848 ■ ↑	2,960 ■ ↔	4,592 ■ ↔	1,605 ■ ↔	2,203 ↔
All BH Providers	809 ■ ↔	861 ■ ↓	1,484 ■ ↓	421 ■ ↓	625 ■ ↓	239 ■ ↔	579 ↔
Psychiatrists	28,153 ■ ↓	- ■	- ■ ↑	21,460 ■ ↑	- ■	5,844 ■ ↔	14,657 ↔
LCDCs	6,033 ■ ↑	2,463 ■ ↓	12,816 ■ ↑	3,012 ■ ↓	2,296 ■ ↓	2,165 ■ ↓	3,417 ↓

■ County's population per provider is lower than or within 10% of Texas average
■ County's population per provider is 10 to 24% above Texas average
■ County's population per provider is 25%+ above Texas average

↓ Population per provider has decreased more than 10% over past 5 years (increasing access)
↔ Population per provider has not changed by more than 10% over past 5 years
↑ Population per provider has increased more than 10% over past 5 years (decreasing access)

A 2011 analysis by the Seton Healthcare Family estimates a shortage of 49 internal medicine/family practice physicians across its 11-county Central Texas service area (which includes all counties in Region 7). With population growth, demographic changes, and replacements for retiring physicians, this shortfall is projected to grow to 377 physicians by 2016.[xxviii] Lee County has the highest population to primary care physician ratio in Region 7, with approximately 4,600 residents per PC physician. DSHS data indicate that in 2011 there were only four PC physicians practicing in the county. Ratios of mid-level providers, particularly APNs, are generally improving across the region.

The population to dental provider ratio in Region 7 counties, with the exception of Travis, is higher than the average across Texas. Within its 2011 Community Needs and Trends Report, the United Way 2-1-1 Navigation Center identified dental care as one of the top unmet needs in Central Texas, particularly in Lee County.[xxix] In qualitative surveys, representatives from Caldwell and Hays Counties also noted access to dental care as a healthcare priority.

With the exception of psychiatrists, ratios of population per specialty care provider are not readily available at the county level. Within its 11-county Central Texas service area, the Seton Healthcare Family estimates a current shortage of 35 medical sub-specialist physicians; this shortfall is projected to grow to 206 medical specialists, 141 surgical specialists, and 53 other specialists (including psychiatry and physical medicine and rehabilitation) by 2016.[xxx] Wait times for specialty clinics at University Medical Center at Brackenridge (UMCB) exceed 6 months for Otolaryngology, Orthopedics, Pulmonary, Ophthalmology, and Podiatry. Gastroenterology and Cardiology both have wait times exceeding 3 months.[xxxi]

Caldwell, Fayette, and Lee Counties have no psychiatrists. Many rural areas are using or are considering the use of telepsychiatry to expand access to care. Shortages in specialty areas, including psychiatry, are particularly acute for subpopulations such as children or seniors.

Safety Net Providers

Safety net providers in Region 7 offer health services to people with limited access to care. Table 5 below displays the type and number of safety net facilities in Region 7 including Federally Qualified Health Centers (FQHCs), other safety net clinics, and Local Mental Health Authorities (LMHAs). LMHAs are public entities designated by the State of Texas to use state allocated funds to serve, people under 200% of the federal poverty level who are diagnosed with bipolar disorder, major depression or schizophrenia.

Table 5. Region 7 Safety Net Providers by County

	FQHCs (# locations)	**Other Safety Net Clinics** (# locations)	**LMHAs**
Bastrop	Lone Star Circle of Care (planned)	Smithville Community Clinic (1)	Bluebonnet
Caldwell	Community Health Centers of South Central Texas (1)	Seton Lockhart Family Health Center (1)	Bluebonnet
Fayette	Tejas Healthcare (2)		Bluebonnet
Hays	CommuniCare (2)	Hays County (2)	Hill Country MHDD
Lee			Bluebonnet
Travis	CommUnityCare (21) Lone Star Circle of Care (1) People's Community Clinic (1)	Seton Community Clinics (3) Volunteer Healthcare Clinic (1) El Buen Samaritano (1)	Austin Travis County Integral Care

Acute Care and Crisis Services

Two hospital systems, Seton Healthcare Family and St. David's Healthcare, provide the majority of the inpatient care in the region with 10 facilities. Region 7's inpatient infrastructure is concentrated in Travis County, which includes more than 2,400 inpatient beds. University Medical Center at Brackenridge (UMCB), owned by Central Health and operated by Seton Healthcare Family, is the region's safety net hospital and only Level 1 Trauma Center for adults. Seton also operates Dell Children's Medical Center, which includes a pediatric Level 1 Trauma Center and inpatient care for children across Region 7 and other counties. Other hospitals in the region include Central Texas Medical Center in Hays County, and St. Mark's Medical Center in Fayette County. Lee County has no inpatient facilities.[xxxii]

All psychiatric inpatient beds for Region 7 are located in Travis County. Currently, two private psychiatric hospitals, Seton Shoal Creek Hospital and Austin Lakes Hospital, have a total of 146 beds. Austin State Hospital is a state-funded 299 bed facility that serves a 38-county region. Seton Shoal Creek Hospital is Region 7's only hospital-based inpatient chemical dependency facility (22 beds).

In addition to inpatient care, Region 7 has a variety of behavioral health crisis services, including psychiatric emergency services, crisis stabilization beds, and mobile crisis outreach teams. Depending on the provider for each service, access may be limited only to residents in certain counties. Region 7 does not have a dedicated psychiatric emergency room, and patients often seek care at local hospital emergency departments which are not staffed or designed to handle persons in psychiatric crisis. The region does not have any psychiatric beds in acute medical/surgical hospitals to accommodate the treatment of patients with co-occurring medical and psychiatric issues. A recently convened planning process for behavioral health stakeholders from Travis County identified inadequate services throughout the continuum of care for individuals with behavioral health issues.[xxxiii] Identified shortages include:

- Prevention and supported recovery;
- Screening, outpatient treatment, and integrated care;
- Intensive outpatient, supported housing, and residential treatment; and
- Crisis stabilization services, detoxification services, medical/psychiatric beds, and inpatient capacity.

Potentially Preventable Utilization and Lack of Care Coordination

A 2011 analysis of emergency department (ED) visits by uninsured and underinsured patients in Travis County found that almost 50% of ED visits were for services that could have been provided in a primary care setting. An additional 6% required emergent care which potentially could have been prevented with appropriate ambulatory care.[xxxiv] Similarly, planning data indicate that approximately 50% of patients in the Seton Edgar B. Davis Hospital ED, located in Caldwell County, could be seen in a more appropriate setting where preventive care, education, and disease management could better be coordinated.[xxxv]

In addition, adult residents of Region 7 have more than 8,500 potentially preventable inpatient hospitalizations per year for conditions such as bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and diabetes complications. Potentially preventable conditions requiring inpatient care contributed to over $1 billion in hospital charges in Region 7 between 2005 and 2010.[xxxvi]

Qualitative data collected through surveys and from providers indicate a need for better coordination across settings of care, including physical and behavioral healthcare systems. These issues tend to arise from a lack of co-located services, separate funding streams, lack of effective information technology systems to communicate and share information among different types of providers.[xxxvii]

People with co-morbidities, including multiple physical health conditions and co-occurring physical and behavioral health concerns, require a variety of health care services that, when delivered in multiple locations by different providers, can lead to costly duplicative care that does not improve health outcomes. Goals identified by Region 7 partners include investing in patient-centered, integrated, comprehensive care that is coordinated across systems and reducing health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Rural Access Issues

Qualitative surveys from all rural areas of the region identified struggles with recruiting and retaining physicians. Though provider to population ratios have improved for some provider types in rural counties, qualitative surveys indicate that existing providers are aging toward retirement. These situations, combined with population growth, could lead to further limitations on access to care.

Previous needs assessments for Region 7 counties, qualitative surveys from every county in the region, and discussions with county leaders all highlight transportation as a critical challenge for healthcare access in rural areas and for low-income populations in urban areas. Because of great distances between residents and services, effective emergency medical transportation can be challenging as well.[xxxviii,xxxix]

Technology

Through the Integrated Care Collaboration (ICC), safety net providers in Central Texas have a Health Information Exchange (HIE) to share clinical data across more than 100 provider locations. These providers include hospital systems, FQHCs, LMHAs, local health departments, and numerous community and faith-based clinics.

Organizations contributing data to the HIE are concentrated primarily in Travis, Hays and Caldwell Counties as well as Williamson County (located in Region 8). There are currently no participating organizations in Lee or Fayette Counties, although encounter data are available for uninsured and under insured patients from these counties who receive care at other participating locations.

The current HIE contains a variety of demographic data, including patient name, date of birth, race/ethnicity, social security number, phone number, and current address as well as administrative data such as encounter location, encounter type (clinic, emergency, inpatient), service date, ICD-9 and CPT-4 procedure codes, and attending provider. Most organizations submit data on a regular basis.

Some limitations of the existing system include limited availability of critical clinical data, such as laboratory and radiology test results, as well as a limited interface for case management, referral data, and analytical capabilities to identify trends and manage the health of select populations.

Federal Funding Initiatives

Providers in Region 7 participate in a variety of federal funding initiatives aimed to address some of the challenges identified in this assessment. The table below outlines current initiatives funded by the U.S. Department of Health and Human Services. The projects proposed in Region 7's RHP Plan do not duplicate these initiatives but build on these investments to further health delivery system reform.

Table 6. Federal Funding Initiatives in Region 7

HHS Funding Initiatives		Recipient
CMS Innovation Center	Pioneer ACO Model	Seton Healthcare Family
HITECH	Medicare and Medicaid Electronic Health Records Incentive Program for Hospitals	Seton Healthcare Family, including UMC Brackenridge and Dell Children's Medical Center
CDC	Childhood Obesity Research Demonstration Grant	Dell Children's Medical Center
CDC	Immunizations Grant	Austin Travis County Health and Human Services Department
CDC	Vaccines for Children Grant	Austin Travis County Health and Human Services Department
SAMHSA	Substance Abuse Prevention and Treatment Block Grant	Austin Travis County Health and Human Services Department
SAMHSA	Community Mental Health Services Block Grant (through Department of State Health Services)	Austin Travis County Integral Care
SAMHSA	Community Mental Health Services Block Grant (through Department of State Health Services)	Bluebonnet Trails Community Services
SAMHSA	Co-Occurring Psychiatric and Substance Use Disorder Services Grant (through Department of State Health Services)	Hill Country MHDD
Departments of Education, HHS, and Justice	Safe Schools / Healthy Students Grant	Austin Independent School District

Expected Changes and Implications

Region 7 counties currently experience shortages in healthcare access, particularly for certain populations. Population growth in the region will create even more demand for health care access in the future. The

new emphasis on prevention and early treatment coupled with a reduction in utilization of emergency department services are expected to create further demand on already limited primary care capacity.

New healthcare facilities planned for Region 7 include a satellite FQHC site opening in Bastrop in 2013 that is expected to serve 17,500 patients. Austin Oaks Hospital, a new 80 bed psychiatric treatment facility, will open in Travis County in the spring of 2013, increasing the number of private psychiatric beds in the region to 226. With expected population growth through 2030, a draft analysis of comprehensive crisis stabilization services in Travis County identified a shortfall of more than 100 inpatient psychiatric beds if no new facilities are added.[xl] Population growth in other Region 7 counties will further exacerbate this lack of inpatient beds.

Within Travis County, Central Health and Seton Healthcare Family, along with Austin Travis County Integral Care, are partnering to create an ACO-like integrated healthcare delivery system that will expand care to a high-need, low-income population by providing services that both support health and better connect preventive, primary, specialty, and hospital care. State Senator Kirk Watson is also leading an effort to build a new medical school in Austin and a modern teaching hospital/regional trauma center, as well as expand comprehensive cancer care.[xli] These initiatives provide opportunities to transform healthcare delivery in Travis County and improve access and care for Region 7 as a whole.

D. Key Health Challenges

The following sections outline key health conditions and challenges for Region 7, including chronic disease, behavioral health, communicable disease, and maternal and child health.

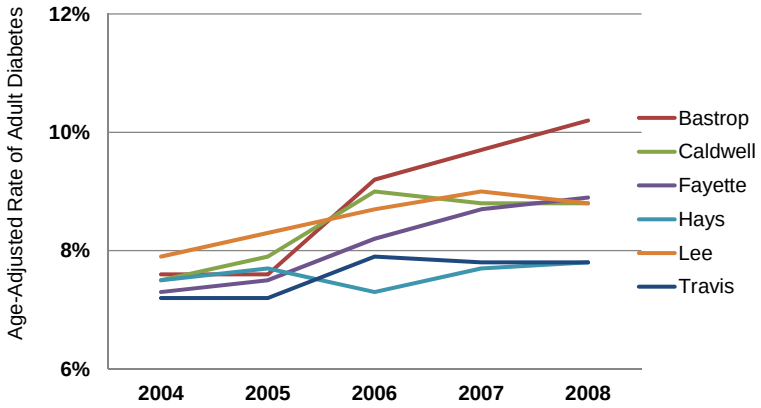
Chronic Disease

Stakeholders across Region 7 identified chronic conditions as a top health concern. Cardiovascular disease, cancer, and pulmonary disease are among the leading causes of death in Region 7.[xlii] Rising rates of obesity and physical inactivity are critical factors contributing to diabetes and other chronic conditions.

Diabetes

Diabetes affects more than 70,000 adults in Region 7.[xliii] With the exception of Hays and Travis Counties, rates of adult diabetes in Region 7 exceed the Texas state average. Figure 4 shows the age-adjusted rate of adults with diabetes between 2004 and 2008, suggesting that rising rates of diabetes across most counties are influenced by factors other than age. Bastrop County experienced the sharpest increase between 2004 and 2008.[xliv]

Figure 4. Region 7 Age-Adjusted % of Adults with Diabetes, 2004-2008



Cardiovascular Disease

Cardiovascular disease (including heart disease and stroke) is the leading cause of death in Region 7. Cardiovascular disease accounts for 39% of deaths in Fayette County, the highest proportion in the region and notably higher than the state average (31%), even after accounting for its older population.[xlv] In addition, congestive heart failure represents one of the leading contributors of potentially preventable hospitalization costs in Region 7 from 2005-2010.[xlvi]

Despite an overall downward trend for stroke in Central Texas, there has been a slight upward trend in recent years in the rate of deaths attributed to stroke for those who are ages 45 to 64.[xlvii]

Cancer

Cancer is the second leading cause of death in Region 7. Although the total number of deaths is smaller, Bastrop County demonstrates the highest proportion of deaths (24%) and the highest age-adjusted death rate attributed to cancer.[xlviii] Among Travis County residents, lung cancer contributes to the greatest number of deaths, followed by colon and breast cancer.[xlix] Breast cancer and prostate cancer represent the greatest volume of new cancer cases in both Travis and Hays Counties, the only counties with available estimates.[l]

Pulmonary Disease

Following cardiovascular disease and cancer, chronic obstructive pulmonary disease (COPD) is one of the leading causes of death in Region 7.[li] In addition, COPD is one of the leading contributors of potentially preventable hospitalization costs in Region 7 from 2005-2010.[lii]

DSHS Health Service Region 7 data for 2009, which includes all Region 7 counties, indicate that 9.3% of children and 7.1% of adults have asthma. These prevalence rates exceed statewide averages of 8.2% for children and 6.5% for adults.[liii]

Contributing Factors to Chronic Disease

Adults in Region 7 tend to be more obese and less physically active compared with national benchmark data.[liv] With the exception of Lee County, the age-adjusted rate of adult obesity rose across all counties in Region 7 between 2004 and 2008. As with diabetes, Bastrop County recorded the sharpest increase. Travis County has the lowest proportion of obese adults but one of the highest rates of increase in obesity. Physical inactivity rates increased slightly across most counties between 2004 and 2008 but rose by almost 25% in Lee County during that time.[lv]

Among counties in the region with data available, Hays County has the lowest rate of adults who smoke (14%), while Caldwell County has the highest (19%).[lvi] Tobacco use is the leading cause of preventable death in Travis County.[lvii] Refer to Table 7 for a summary of contributing factors to chronic disease across Region 7 counties.

Table 7. Region 7 Comparison of Contributing Factors to Chronic Disease from 2012 County Health Rankings[lviii]

Comparison of Health Factors	National 90th Percentile	Bastrop	Caldwell	Fayette	Hays	Lee	Travis	Texas
Adult Obesity	25%	31% ■ ↑	32% ■ ↑	29% ■ ↑	30% ■ ↑	31% ■ ↔	25% ■ ↑	29% ■
Adult Physical Inactivity	21%	27% ■ ↔	25% ■ ↔	28% ■ ↔	26% ■ ↔	30% ■ ↑	18% ■ ↔	25% ■
Adult Smoking	14%	N/A	19% ■	N/A	14% ■	N/A	17% ■	19% ■

■ County's rate is lower than or within 10% of national benchmark
■ County's rate is 10 to 49% above national benchmark
■ County's rate is 50%+ above national benchmark
↓ Rate has decreased more than 10% over past 5 years
↔ Rate has not changed by more than 10% over past 5 years
↑ Rate has increased more than 10% over past 5 years

Maternal and Child Health

Across Region 7 counties, approximately 37 to 43% of mothers do not receive prenatal care in the first trimester. Mothers in Caldwell County have the lowest rate of timely prenatal care as well as the highest rate for teen births and low birthweight infants (see Table 8 below).[lix,lx]

Table 8. Region 7 Key Maternal and Child Health Indicators by County

	Bastrop	Caldwell	Fayette	Hays	Lee	Travis	Texas
% Prenatal Care in First Trimester [59]	62.9%	56.4%	62.5%	63.0%	58.9%	59.7%	58.4%
Teen Births [60] (per 1,000 females ages 15-19)	54	75	43	32	41	54	63
% Low Birthweight (< 2,500 grams) [60]	7.3%	8.2%	8.0%	7.1%	7.2%	7.4%	8.2%

Communicable Disease

Sexually Transmitted Diseases

Chlamydia is the most frequently reported sexually transmitted disease in Region 7. The rate of chlamydia in Hays and Travis Counties is significantly higher than the Texas state average and higher than rates for other Region 7 counties. Travis County also demonstrates the highest rates of gonorrhea, syphilis, and HIV/AIDS compared with other counties in Region 7.[lxi] More than 3,500 people in Travis County are living with HIV or AIDS.[lxii]

Vaccine Preventable Diseases

Bastrop, Caldwell, and Travis Counties all demonstrate rates of pertussis (whooping cough) that are significantly higher than the Texas state average.[lxiii] Within Central Texas, rates of pertussis, mumps, and tuberculosis have been generally increasing since approximately 2008.[lxiv]

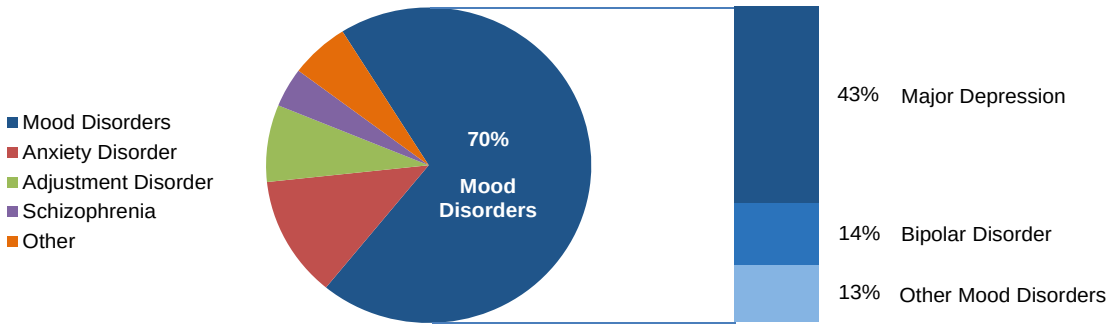
Behavioral Health

The available data for behavioral health are from disparate sources because reliable data across counties does not exist. However, estimates suggest that over 20% of Region 7 residents below 200% of FPL who have a severe mental illness (including substance use disorder), and over 50% who have any type of behavioral health disorder are not receiving care.[lxv]

Top Behavioral Health Conditions

Data from multiple sources indicate that mood disorders including major depression and bipolar disorder are the most common behavioral health diagnoses in the region, representing approximately 70% of behavioral health diagnoses. Figure 5 below depicts the prevalence of behavioral health conditions from a Travis County FQHC. The data presented mirror other data sources for the region.

Figure 5. Prevalence of Behavioral Health Conditions Among Consumers at an FQHC[lxvi]



Inpatient Psychiatric Discharges

Caldwell, Hays, Lee, and Fayette counties experienced modest increases in inpatient psychiatric hospitalizations from 2006-2010 whereas inpatient hospitalizations decreased in Bastrop County. Travis County experienced a 33% increase in inpatient hospitalizations from 2008 to 2010.[lxvii,lxviii]

Suicides

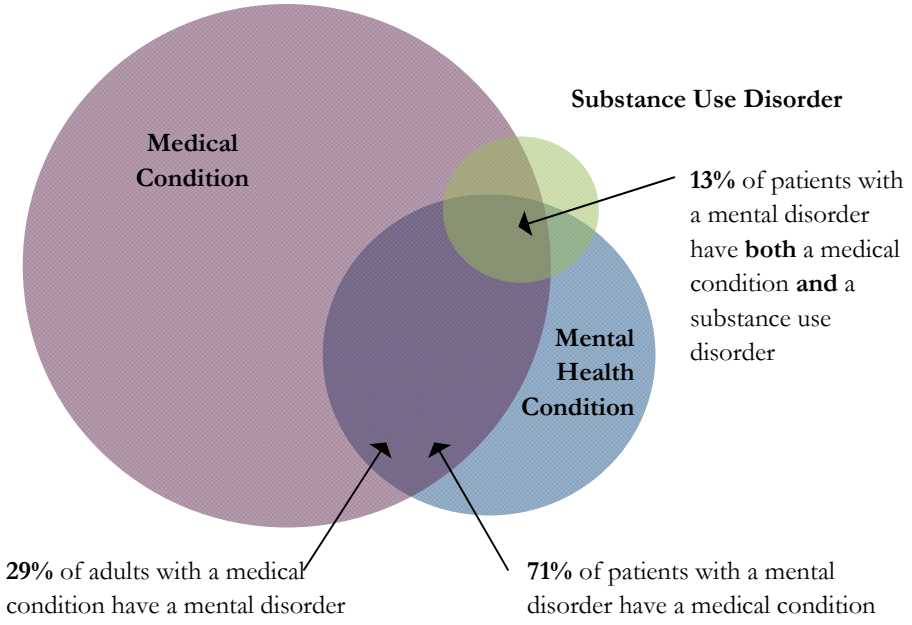
Despite minor fluctuations, the numbers of suicides have remained relatively stable across the five years of data for all Region 7 counties with the exception of Hays and Bastrop counties. Over the five-year period, the number of suicides in Hays Country trended downward; however, in Bastrop County they trended upward.[lxix] In Travis County, suicides are the 8th leading cause of death and the 4th leading preventable cause of death.[lxx]

Co-Occurring Conditions

Patients with multiple chronic conditions have a higher risk of potentially preventable hospitalizations, contribute to higher healthcare costs, and are a greater challenge for coordination of care.[lxxi] Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition.[lxxii]

Nationwide, 29% of adults with a medical condition also have a mental health diagnosis.[lxxiii] Moreover, over 71% of Travis County patients with a mental health diagnosis also experienced a co-occurring medical condition, and over 20% experienced a substance use disorder, while almost 13% experienced all three conditions. Of Travis County patients with a substance use disorder, 65% had a mental health diagnosis, 70% had a medical diagnosis, and 41% were diagnosed with all three conditions.[lxxiv] The following diagram illustrates the overlapping prevalence of co-occuring conditions.

Figure 6. Prevalence of Psychiatric, Substance Use, and Medical Co-Morbidity Among People in Travis County



Specific Populations

Specific populations within Region 7 require special consideration for healthcare services. Among Central Health MAP enrollees, homeless persons have higher utilization across all types of care, particularly emergency and inpatient psychiatric services.[lxxv] Approximately 21% of homeless people are considered to be severely mentally ill, and 33% have a chronic substance abuse disorder.[lxxvi] Local stakeholders across Region 7 also have identified persons with intellectual and developmental disabilities (IDD) as a population with unique behavioral health challenges. Indeed, across Region 7, over 60% (range 60% to 80%) of residents with an IDD diagnosis also had a medical condition, and over 35% (range 35% to 57%) had a psychiatric condition.[lxxvii]

Stakeholders across Region 7 indicate a need for an increased focus on healthy lifestyles and disease prevention for children and adolescents with health risk factors such as obesity. At middle schools in the Austin Independent School District, the percentage of overweight and obese students ranges from 18.7% to 48.1%.[lxxviii]

Children's behavioral health services are provided through numerous settings and provider types, such as through primary care physicians, mental health providers, and the school setting. With more than 226,000 school-aged children (between the ages of 5 and 18) in Region 7, national prevalence data suggests that approximately 47,000 school-age children within Region 7 experience some form of mental illness.[lxxix] Examination of data specific to Travis County indicates that the number of unique patients (under 24 years old) with behavioral health diagnoses has increased every year since 2006.[lxxx]

Rates of diabetes and other chronic diseases tend to become more prevalent with advancing age, and an older population will contribute to additional demand for healthcare resources. In qualitative surveys, representatives from multiple counties cited the aging population as a top health concern. Furthermore, national studies have identified a lack of providers adequately trained to treat geriatric behavioral health and substance abuse issues.[lxxxi]

Health Disparities

Available data show disparities across many health conditions, likely to be exacerbated by an increasingly diverse population. More detailed data typically are available for larger counties; unless otherwise noted, data from the Austin/Travis County Health and Human Services Department are used below to illustrate racial and ethnic, age, and other disparities.[lxxxii]

Among Travis County residents, diabetes disproportionately affects Blacks and Hispanics, with a death rate more than double that of Whites. The rate of diabetes and other chronic conditions also generally increases for older residents.

Compared with Whites, Blacks and Hispanics experience much higher rates of factors contributing to chronic disease, including obesity and physical inactivity. Travis County adults with lower incomes are also less likely to be physically active than those with higher incomes.[lxxxiii] For middle-school children at Austin Independent School District, the prevalence of obesity exceeds 20% among Black and Hispanic children compared to 9% for Whites.[lxxxiv]

Blacks have disproportionate rates of death attributed to heart disease, cancer, and HIV/AIDS compared with Whites or Hispanics. A 2008 Hays County Health Assessment also found that the rate of death from cancer for Blacks in Hays County exceeded other area counties and was 16% higher than the statewide average for Blacks.[lxxxv] Conversely, mortality rates for cardiovascular disease, cancer, and HIV/AIDS tend to be lowest among Hispanics.

Black and Hispanic mothers have higher rates of teen births and lower rates of timely prenatal care than White mothers. Compared with Hispanic and White mothers, Black mothers also have more than twice the rate of low birthweight babies and infant mortality.

Expected Changes and Implications

Chronic conditions are the current leading causes of death in Region 7. Diabetes rates are rising across most counties, with Bastrop County increasing more than 30% between 2004 and 2008. Rising rates of contributing factors such as physical inactivity and obesity will contribute to further increases in chronic disease if current trends remain unchanged.

Forty percent of mothers in Region 7 do not initiate prenatal care within the first trimester which may lead to poor health outcomes for babies and families that require costly, preventable care. Population growth in the region could increase the number of babies born without adequate prenatal care. Compared with

babies born to mothers who received appropriate prenatal care, babies of mothers who received *no* prenatal care are three times more likely to be low birthweight and five times more likely to die in infancy.[lxxxvi]

Many Region 7 residents have co-morbidities, including multiple physical health conditions and co-occurring physical and behavioral health concerns, which pose significant challenges for achieving good population health outcomes. More and more, Region 7 delivery systems are recognizing the need to address these issues simultaneously. Achieving these improved outcomes will require integration of healthcare delivery that bridges and integrates currently separate physical and behavioral health delivery systems.

Finally, population growth and the increasing diversity of Region 7 may exacerbate existing disparities in health outcomes among different racial and ethnic groups. An aging population will also contribute to additional demand for specialists as well as the need for resources to address chronic conditions, dementia, stroke, and other age-related health conditions.

Conclusions

Overall, Region 7's expected population growth will lead to greater demand for healthcare services, including primary care, specialty care, and behavioral health. More than sheer numbers, the increasing diversity of the population will require additional skills among the provider population in order to deliver care that can effectively cross cultural and language boundaries and ensure positive health outcomes. Finally, Region 7's growing aging population will likely create additional demand on healthcare infrastructure.

Chronic conditions, including behavioral health issues, are prevalent among Region 7's population, and the community lacks key psychiatric crisis continuum infrastructure. People with co-morbidities, including multiple physical health conditions and co-occurring physical and behavioral health concerns, are required to navigate a complicated and disconnected system of healthcare providers. Goals identified by Region 7 partners include investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

Community Needs Summary Table

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need (See Addendum A)
CN.1	Inadequate access to primary care	24,25,27,28
CN.2	Inadequate access to specialty care	25,30,31
CN.3	Inadequate access to dental care	24,25,27,29
CN.4	Inadequate access to behavioral health care	24,25,27,33
CN.5	Transportation access for people in the rural areas and also for low-income populations in urban areas	38,39
CN.6	Inadequate services throughout the continuum of care for individuals with behavioral health issues such as: • Prevention and supported recovery • Screening, outpatient treatment, and integrated care • Intensive outpatient, supported housing, and residential treatment	33

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need (See Addendum A)
	• Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care	
CN.7	Lack of coordination of care across: • Settings of care • Multiple conditions • Physical and behavioral health	33,37
CN.8	High rates of non-emergent emergency department usage and potentially preventable inpatient admissions	34-36
CN.9	High rates of chronic disease such as: • Cardiovascular disease • Cancer • Rising rates of diabetes	42-53
CN.10	Many residents in Region 7 have multiple chronic conditions	71,72
CN.11	Rising rates of physical inactivity and obesity	54,55,58
CN.12	Lack of adequate prenatal care	59,86
CN.13	Higher rates of STDs in Travis County than Texas state averages	61,62
CN.14	Rising incidence of vaccine preventable conditions, including • Pertussis • Mumps • Tuberculosis	63,64
CN.15	Additive and costly impact of co-occurring mental health, substance use, and medical conditions	33,73,74
CN.16	Lack of services for specific populations such as: • Homeless • Children • Aging and elderly	75-81
CN.17	Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions	12,82-85
CN.18	Tobacco use remains a leading cause of preventable death	56-68

Section IV. Stakeholder Engagement

Stakeholder Engagement Overview

Region 7 developed its RHP plan through a comprehensive process that involved RHP participants, local service providers, key stakeholders, and the public. As anchor, Central Health used a variety of communication processes to engage as many stakeholders as possible into the RHP plan for input and plan development. A summary of the processes include:

- Maintained a comprehensive website, www.texasregion7rhp.net to post drafts of the RHP plan (e.g., Community Needs Assessment, DSRIP projects, RHP Vision and Goals), to keep RHP stakeholders apprised of significant developments and events in the RHP planning process. The website also contained educational and background information to educate interested parties, including links to HHSC resources.
- Hosted more than 100 meetings with RHP participants and community stakeholders to educate interested parties and stakeholders on the 1115 waiver to identify community needs and discuss possible projects to address those needs, and the roles of service providers.
- Participated in more than 15 1115 waiver presentations to community groups that requested them.
- Hosted four region-wide public hearings at various locations around the region to receive comment on draft DSRIP projects and the full draft RHP plan.
- Maintained a comprehensive email list of stakeholders to provide up-to-date information on RHP plan development, including public comment opportunities.
- Hosted five work sessions with RHP participants and community provider groups to collaboratively develop regional vision and goals and to develop and refine DSRIP projects in a collaborative setting.
- Hosted technical assistance sessions throughout the RHP plan development process.
- Facilitated six discussions among the region's Local Mental Health Authorities (LMHAs) to facilitate a regional response to Region 7's significant behavioral health concerns.

RHP Participants Engagement

To begin regional planning, Central Health hosted a region-wide meeting with regional stakeholders and interested parties on March 2, 2012. More than 70 participants representing 32 different organizations came together to discuss the opportunities available in the 1115 waiver, identify major community needs to be addressed, to lay out expectations for community collaboration, and to develop an overall structure to begin the development of a regional plan to promote health care system transformation.

]After the initial meeting, Central Health staff followed up with an introductory letter to a broad range of local officials in the region, including mayors, city council members, county commissioners, and county judges to inform them of the waiver and to offer assistance. See Addendum B for a sample of this letter. Central Health staff also conducted individual meetings with local government officials in each RHP Region 7 county to educate them on the waiver and explain the waiver participation requirements.

Central Health staff also facilitated joint meetings with county officials and performing providers to begin discussing community needs and how they may be addressed. At each meeting, Central Health focused on communicating the requirements of the waiver and the opportunities to leverage funding to make significant improvements in the delivery of health care services. Central Health also developed a

comprehensive binder of information to document the waiver program requirements for all parties. See Addendum C for copies of binder contents.

Further, Central Health surveyed regional stakeholders to gain additional community need information. See Addendum D for a copy of the survey. Responses were received from each of the six counties in the region and were used to validate or expand upon quantitative data included in the assessment.

Stakeholders and interested parties also participated in a region-wide meeting to develop the RHP 7 region vision and goals. There was widespread participation across stakeholders in the development of the vision and goals, with region-wide consensus that the 1115 Waiver offered opportunities to provide better access to lower-income patients in the proper setting, at the right time, and in an effective manner.

Central Health also hosted technical assistance throughout the RHP plan process. Technical assistance was provided through regularly scheduled phone conferences (similar to the anchor calls conducted by HHSC). The calls were designed to disseminate information and answer specific questions regarding the waiver. In addition, several group technical assistance meetings were conducted to discuss specific DSRIP project requirements. DSRIP project authors were able to have group discussions regarding issues in the project development process.

Communication Tools

Central Health maintained continuous communication with RHP participants and stakeholders and the public throughout the waiver process. Different distributions lists were developed to target communications to specific audiences in order to find a proper mix of detail in the information content. Important dates and milestones were communicated to all parties, including the public. All information was also included on www.texasregion7rhp.net which was a key communication tool to disseminate information to interested stakeholders. Communication lists included IGT entities, performing providers, local healthcare providers, county medical societies, key stakeholders, local government officials, and the public.

Plans for Ongoing Engagement with RHP 7 Participants

During RHP 7 plan implementation, Central Health will maintain the website www.texasregion7rhp.net and use email as primary communication tools. Central Health also will conduct semi-annual meetings of RHP participants to conduct anchor-arranged collaborative learning groups. Technical assistance will continue to discuss regional reporting issues and DSRIP project progress status. Central Health will also host learning collaboratives, which will be an essential process in sharing best practices and lessons learned throughout the 1115 Waiver period. Going forward, Central Health will work with RHP 7 participants to develop methods and processes for measuring and tracking progress on metrics and milestones to assure system transformation.

B. Public Engagement

Across the region, the public and interested stakeholders had full opportunity to learn about the waiver, provide input into DSRIP project development in both oral and written formats, and offer comment on

the full RHP plan before final submission to HHSC. Communication with public stakeholders was accomplished primarily through Region 7's website (www.texasregion7rhp.net), emails, and multiple public hearings conducted in various locations across the region. Central Health made concerted efforts to collect public input in sufficient time to inform decisions about final plan development.

One of the initial strategies was to educate public officials to inform them of the requirements and opportunities of the 1115 waiver. Overall, this was an important strategy, as it allowed public officials to engage their constituency to discuss waiver options, including budgetary impact to participate in funding decisions. Central Health staff also made more than 15 presentations to community groups throughout the RHP plan development process to update stakeholders on project status, answer questions, and receive input.

Website

The Central Health website, www.texasregion7rhp.net, was also a critical tool that was utilized to communicate with the public. Draft documents were posted, along with the posting of public meetings for the public to provide input. The website's launch and major information updates to the site were announced also by email. The public had opportunities to provide feedback at the public hearings or through a comment section located on the website throughout the development process.

Public Input for DSRIP Projects and Full Plan Draft

Central Health actively solicited public input at multiple points in the Region 7 plan development process. Written comments were accepted online throughout the development process. Stakeholders were notified in advance where and how they could access copies of the draft DSRIP projects as part of the hearing notices. There were also opportunities for public comment on the Community Needs Assessment.

Hearing notices were emailed out in two rounds, with the initial announcement stating the date, time, and place of the public hearing. The second notice was a follow-up and served as a final notice. Central Health also requested that local governmental entities post the meetings in their respective county. Public hearings were conducted in multiple counties, including Bastrop, Hay, and Travis counties

Hearings were recorded and posted on the Region 7 website if any interested parties were not able to attend. Written comments were also accepted if interested parties did not elect to offer public testimony. Feedback on specific projects was forwarded to performing providers and IGT entities if they were not able to attend. Below is a schedule of postings and related public hearings.

Activity	Date/Time	Location
Initial draft DSRIP projects posted online	July 24, 2012	www.texasregion7rhp.net
First public hearing	July 27, 2012/11:15 am	Bastrop County Courthouse
Second public hearing	July 30, 2012/5:30 pm	Central Health (Travis County)
Pass 1 DSRIP projects posted online	October 17, 2012	www.texasregion7rhp.net
Third public hearing	October 22, 2012/11:30 am	Hays County Courthouse
Full Region 7 RHP plan posted online, including Pass 2 and 3 DSRIP projects	December 12, 2012/9:00 am	www.texasregion7rhp.net
Fourth public hearing	December 18, 2012/6:00 pm	Central Health (Travis County); Access available by teleconference

County Medical Society Engagement

The following medical societies operate in Region 7:

Medical Society	County(ies) Served
Bastrop-Lee Medical Society	Bastrop, Lee
Tri-County Medical Society	Hays, Blanco, Caldwell
Colorado-Fayette Medical Society	Colorado, Fayette
Travis County Medical Society	Travis

Central Health, as anchor, reached out to each medical society to provide education on the 1115 waiver, invite them to be involved in RHP plan development, and request a letter of support for the Region 7 RHP plan. To make contact with medical societies outside of Travis County, Central Health relied on local performing providers directly involved with the medical societies to reach out and request their involvement in RHP planning and to gain a letter of support for the RHP plan. In addition to outreach by local providers, Central Health sent a letter to each medical society to solicit input (for copies of the letters, see Addendum E). At the request of the Tri-County Medical Society, Central Health drafted information about the 1115 Waiver to post on its website, and attended a medical society meeting with the local performing provider to answer questions and receive input on RHP plan development. The Travis

County Medical Society attended the region's kick-off meeting on March 2, 2012, participated in multiple meetings throughout the plan development process, and provided a letter of support (see Appendix F) for Region 7's plan.

Plans for Ongoing Public Engagement

To maintain the public's engagement in Region 7 RHP plan implementation, Central Health will maintain www.texasregion7rhp.net as a primary communication tool to provide updates on project status and any new developments or changes to the 1115 waiver program. Annually, the RHP will release a report detailing Region 7 activities for the year. The report will be posted online where Central Health will accept written comments. Central Health will also host a public hearing at the time of report release to take public comments and feedback. Central Health will maintain a staff position responsible for overall waiver coordination. This individual will continue to communicate regularly with RHP 7 stakeholders and will serve as both a resource and a liaison on waiver issues.

SECTION V

A. RHP Plan Development

RHP 7 is a Tier 3 RHP and is required to perform a minimum of 8 projects from Categories 1 and 2, with at least 4 projects from Category 2.

Performing Providers and IGT entities in RHP 7 have proposed a total of 68 projects, with 23 from Category 1 and 45 from Category 2.

- In Pass 1, submitted November 16, 2012, RHP 7 proposed 18 projects, including 5 from Category 1 and 13 from Category 2.
- Pass 2 projects include 5 Category 1 and 19 Category 2, for a total of 24 projects.
- Pass 3 projects include 13 Category 1 and 13 Category 2 projects, for a total of 26 projects.

A summary total of proposed projects by provider type shows:

- 29 projects from LMHAs,
- 6 projects from Local Health Departments, and
- 33 projects from Hospitals.

As the anchor entity, Central Health strongly encouraged projects to have a direct connection to the needs of the community and use the Community Needs Assessment to inform project selection and development. In addition, a significant effort was undertaken to keep participants educated in the changing Program and Funding Mechanics (PFM) Protocols project requirements. Central Health facilitated meeting between IGT entities and performing providers to discuss possible projects to ensure they both addressed community needs and complied with the latest direction from HHSC and the PFM Protocols.

The focus of Pass 1 was to comply with requirements dictated by HHSC in order to be eligible for Pass 2 funding allocations. RHP 7 met the following requirements in Pass 1:

1) Submitted over the minimum number of 8 projects, with at least 4 DSRIP projects in Category 1 and 4 DSRIP projects in Category 2;
2) Saw participation from minimum number of safety net hospitals in DSRIP projects;
3) Private and non-profit hospital participation exceeded the minimum 15% allocation guideline for broad participation.

In addition to meeting the requirements to advance to Pass 2, Pass 1 was characterized by participation from local performing providers: Local Mental Health Authorities (LMHAs) and a Local Health Department (LHD). All LMHAs located in Region 7 utilized their full Pass 1 allocation as provided by HHSC and their state organization.

Pass 2 submissions consisted primarily of LMHA DSRIP projects, with all 3 LMHAs in Region 7 proposing DSRIP projects valued up to their maximum Pass 2 DSRIP allocations as provided by per HHSC allotment formulae.

Region 7 had a large number of Pass 3 projects. Major participation came from the Community Care Collaborative (CCC) and University Medical Center at Brackenridge (UMCB), Performing Providers located in Travis County. The CCC proposed 14 projects and UMCB proposed 12 projects in Pass 3.

All projects in Passes 1-3 were presented to the RHP 7 Governance Committee, formed to oversee the overall RHP plan approval process. The governance committee consists of IGT entities, performing providers, and key stakeholders within Region 7. The governance committee endorsed all DSRIP projects in Pass1, 2 and 3.

In order to be considered a valid project proposal, all performing providers' DSRIP projects were required to have a confirmed funding source. Only one project with confirmed funding was not considered for inclusion in the RHP. This was a project submitted by St. Mark's Medical Center to expand emergency transport services in Lee County. When the emergency transportation option was eliminated as a DSRIP item, this project was withdrawn and was not resubmitted. (See Addendum G for project detail.) There were no regional decisions to exclude projects from the RHP plan.

As the anchor, Central Health hosted an initial region-wide stakeholder meeting in March 2012 to introduce the 1115 Waiver and begin the process of identifying those major community needs to be addressed by DSRIP projects. Central Health initiated additional meetings with local government officials to discuss the technical requirements of the 1115 Waiver and the opportunities for participation.

In summer 2012, Central Health convened a planning and visioning session to discuss and develop a regional vision and regional goals to be achieved through the Waiver. At this meeting, the Region 7 Community Needs Assessment was previewed, and participants were invited to expand upon the ideas and information that were presented.

The RHP 7 vision and goals were developed through this and an addition in-person work session involving RHP Participants and key stakeholders. Several sources, including the Waiver's goals and the draft Region 7 Community Needs Assessment, and individual county-level fact sheets, guided the participants in developing the following goals and vision for the region:

Vision: Good health is achievable for all people in Region 7.

Goals:

1. **Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.** In order to provide the necessary infrastructure to improve the health of current and future residents, it is necessary to invest heavily in electronic information systems to allow providers a comprehensive picture of the patient's health status. A robust information system will allow access to information for primary care, specialty care, behavioral health, and emergency care to providers in order to make informed decisions of care to patients.
2. **Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.** In RHP 7, this is addressed by addressing both physical and behavioral health needs by integrating physical health services and behavioral health services. In 2011, almost 50% of ED visits within Travis County, the major urban area in Region 7, were for services that could have been provided in a primary care setting. RHP 7 Performing Providers will offer new service locations and expand services to existing locations to offer patients the opportunity to receive care in a primary care setting rather than an extensively more expensive ED setting. Expanded specialty care will also be offered to reduce significant wait times that results in more costly patient care. There is also an emphasis to provide navigation to direct patients to the appropriate settings.

3. **Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.** RHP 7 will target services that meet the needs of the population by targeting interventions that will help patients improve their health. Initiatives, such as the Patient-Centered Medical Home, will focus on establishing a patient-centered model of care across all safety net providers and to improve the patient experience of care. This project will establish shared care standards, data exchange protocols, and organizational approaches to care that allow for a coordinated, collaborated provider network to improve patient health management. In addition, addressing both physical and behavioral health needs will be accomplished by expanding behavioral health services at physical health sites and physical health services at behavioral health sites will provide an integrated, comprehensive care model.
4. **Bolster individual and population health by improving chronic disease management.** Chronic care to patients will improve by projects that address on coordinating care for patients with 2 or more chronic conditions. A chronic disease registry will assist a provider care team to ensure patients are receiving the proper care at the proper time, track progress and outcomes of care, identify the need for follow-up care, and identify and target patients with the highest needs. The chronic care management project will establish the clinical and care team guidelines to effectively deliver evidence-based best practices to these patients. It will also emphasize increasing patient capacity for self-care.
5. **Support prevention education and healthy lifestyles to improve population health.** Patient education is supported in RHP 7 through prevention programs to educate targeted population to change behaviors that may result in a less productive life and overall more overall costs to the healthcare system. Programs designed to target high-risk populations include Tobacco Cessation, Adult Immunizations to high-risk patients, and Sexually Transmitted Disease Screening, Treatment, and Prevention.
6. **Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.** RHP 7 has included a large number of programs across the region designed to provide behavioral health services in the right setting. Behavioral programs range from programs that are designed to detect and treat patients by utilizing virtual psychiatric services over the internet to psychiatric services provided in the ED and designed to stabilize patient management for severe cases. There has also been a focus to integrate behavioral and medical services through a team of providers to provide comprehensive services for patients with co-occurring conditions.
7. **Improve the patient experience of care by increasing the quality of care and patient safety.** Overall, the patient experience in RHP 7 will be improved by getting the patient to the appropriate setting to receive the proper treatment. Improving the current fragmented system will provide a more comprehensive patient experience rather than the overutilization of improper and expensive treatment settings. Patient navigation programs will focus on getting the patient to the proper treatment setting.

In keeping with direction from HHSC, project negotiation and selection was left to Performing Providers and their IGT entities. The anchor provided significant technical assistance to ensure that all projects reflected both PFM and RHP Planning Protocol requirements, but did not make any funding decisions throughout the process. Other than funding allocations dictated by HHSC, the anchor entity did not impose any restrictive limitations on allocations to IGT entities or performing providers.

Central Health conducted several workshops with project authors to ensure compliance with DSRIP requirements. Several drafts of projects were submitted to the anchor entity for a review and comment process. The anchor checklist, as provided by HHSC, was utilized to provide structure to the Quality Assessment process to ensure all key elements existed in each project plan submission. Central Health also provided direct technical assistance for specific questions and attempted to resolve in a timely manner. All questions were encouraged to be initially submitted to the anchor, with unresolved questions then submitted to HHSC. The anchor also disseminated information as presented in HHSC anchor calls when necessary.

The focus on Pass 1 was to ensure compliance with HHSC guidelines to ensure that Region 7 could proceed to Pass 2. LMHA entities in Pass 1 adhered to the Community Center allocation provided by HHSC to determine each LMHA performing provider allocation. Pass 2 performing provider allocations were capped per HHSC guidance based on Pass 1 participation. LMHAs in Pass 2 utilized their maximum funding allocations, resulting in LMHAs across the region fully utilizing their total allocations in Pass 1 and Pass 2.

Pass 3 DSRIP projects were submitted to the anchor entity and approved by the Governance Committee. DSRIP projects approved were from two performing providers within Travis County; the Community Care Collaborative and University Medical Center at Brackenridge.

There are no hospital-based Performing Providers that are exempt from Category 4 reporting.

B. Project Valuation

Following direction from HHSC, Central Health, the anchor of Region 7, did not impose a valuation calculus on its members. Instead, the Anchor provided Performing Providers and IGT entities with a number of suggested factors for deriving their valuation methodologies. Working within available IGT funding, Central Health offered the following suggestions to aid Performing Providers:

1. Triple Aim Factor:
   Relative to other proposed projects, to what extent does this DSRIP project …

   - Improve the health of the defined population?
   - Enhance the patient care experience (including quality, access and reliability)?
   - Reduce, or at least control, the per capita cost of care?
2. Waiver Goals Factor:
   Relative to other proposed projects, to what extent does this DSRIP project …

   - Support development and maintenance of coordinated care delivery system?
   - Improve outcomes while containing cost growth?
   - Improve and prepare the health care infrastructure to increase access to services?
   - Make a transition to quality based payment systems?
   - Improve coordination in the current indigent care system?
3. Community Needs Factor:
   Relative to other proposed projects, to what extent does this DSRIP project …

   - Address Community Needs outlined in Community Needs Assessment?
   - Primarily impact the Medicaid or uninsured population?
4. Investment Size Factor:
   Relative to other proposed projects…

   - How large is the expected investment to implement the project and achieve its associated metrics and milestones? Considerations include: Personnel; Equipment; Time; Complexity.
5. Project Scope Factor:
   Relative to other proposed projects…

   - How large is the scope (or impact) of this project? Considerations may include: Number of patients affected; Type of patients affected; Patient visits &/or encounters; Additional providers recruited and/or trained; Costs avoided; Ripple effect on all payers.

Having received these suggested factors, Performing Providers and IGT entities were free to develop and utilize their own valuation methodologies. Within the region, variation for similar projects is likely to vary based on size, complexity, scope of services, funding availability, and other various factors.

One notable difference in valuation approach is that taken by the Local Mental Health Authorities (LMHAs). Statewide, LMHAs chose to utilize the Quality Adjusted Life Year (QALY) as a measure of the value of each LMHA intervention. Their valuation narratives reflect these assumptions.

Austin Travis County Integral Care
Category 1 DSRIP Projects

Austin Travis County Integral Care

Mental Health First Aid and Suicide Prevention

Project Identifier: 133542405.1.1 Pass 2

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has been committed to providing services for children, families and adults with behavioral health disorders. In fiscal year 2011, more than 23,000 individuals and families received services from ATCIC, of who 10,000 were adults with serious mental illness (SMI). ATCIC is the Local Mental Health Authority for Travis County and Joint Commission accredited.

Intervention(s): This project proposes the development and implementation of an evidenced-based training program in mental health and suicide prevention for primary care staff such as physicians, nurses, physician assistants, and administrative assistants. Consumers with behavioral healthcare needs served by trained primary care staff will be linked to appropriate care through increased referrals to integrated health care within the primary care setting, expanded behavioral health outpatient services, ATCIC's Mobile Crisis Outreach Team and/or Psychiatric Emergency Services.

Need for the project: Currently, there are no existing training programs that meet the needs of primary care staff who, given the context of their work, frequently encounter individuals who have a mental illness, experience a mental health crises and are at risk of suicide. Forty percent of individuals with mental health problems initially seek care in primary care settings and well over half of all primary care patients present with co-morbid psychiatric illness. One out of every two patients seen by primary care staff has a co-occurring mental illness. Research indicates only 20 to 30 percent of patients with mental health problems report them to their primary care physicians. Without adequate training to recognize behavioral health problems among patients and to manage mental health crises including suicidal risk, patients' critical needs go unmet. Many of those patients with more acute needs end up seeking care in emergency departments. Primary care staff are aware they lack training and report that they are unprepared to meet the behavioral health needs of their patients. With suicide as the eighth leading cause of death in Travis County, failure to recognize and treat suicide risk could result in loss of life

Target population: The target population for the project includes more than 62,000 Medicaid eligible or indigent patients served by the 1, 350 primary care staff in Austin and Travis County who will be trained in Mental Health First Aid and suicide prevention.

Category 1 or 2 expected patient benefits: The project will benefit an estimated 100,344 patients with behavioral health needs served in primary care settings. Patient needs will be identified and referred to appropriate treatment and diverted from unnecessary emergency.

Category 3 outcomes: IT-6.2: Our goal is to reduce the number of emergency department visits for behavioral health conditions by 10 percent for patients previously served by trained primary care staff.

Title of Project: **Mental Health First Aid and Suicide Prevention**

Category / Project Area / Project Option: **1.2.5**

RHP Project Identification Number: **133542405.1.1 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **0133542405**

Project Description

Overall Project Description - Austin Travis County Integral Care (ATCIC) proposes the development and implementation of an evidenced-based training program in mental health and suicide prevention for primary care staff such as physicians, nurses, physician assistants, and administrative assistants. Currently, there are no existing training programs that meet the needs of primary care staff who, given the context of their work, frequently encounter individuals who have a mental illness, experience a mental health crises and are at risk of suicide.

The proposed training program will use evidence-based curricula to train primary care staff on how to identify, understand and respond to signs of mental illnesses and chemical dependency disorders and how to prevent suicide. The primary curriculum for the program is Mental Health First Aid (MHFA), which is an interactive 12-hour course on the following: mental illnesses and associated disorders, risk factors and warning signs related to mental health, suicide risk identification and intervention, the impact of mental illnesses to families and communities, and an overview of common treatment approaches. Staff who complete the 12-hour course (1) learn a five-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care and (2) earn a certification in MHFA.

An additional curriculum geared specifically to suicide prevention, called Recognizing and Responding to Suicide Risk in Primary Care (RRSP-PC) will be implemented throughout primary care settings. RRSR-PC is a one-hour training program that provides physicians, nurses/nurse practitioners and physician assistants with the knowledge they need in order to integrate suicide risk assessments into routine office visits, to determine risk, and to work collaboratively with patients to create treatment plans.

All MHFA and RRSP-PC training will be offered on-site at primary care clinics or at ATCIC's training facilities. A web-based training will also be made available for primary care staff to be trained in suicide prevention.

The critical need for these trainings is evidenced by prevalence research. For example, in any given year, one in four adults in the Unites States experience a diagnosable mental illness and almost half of all adults will experience mental illness in their lifetime.[1] Six percent will experience severe mental illness. Forty percent of individuals with mental health problems initially seek care in primary care settings and well over half of all primary care patients present with co-morbid psychiatric illness.[2]

The most significant crisis associated with mental health problems is suicide. More than 32,000 people in the United States die by suicide every year.[3] It is this country's eleventh leading cause of death. In Travis County suicides are the eighth leading cause of death and the fourth leading preventable cause of death.[4] In Austin Texas , there were 110 deaths attributed to suicide in 2010 and 99 suicides in 2011.[5] Despite the

overwhelming prevalence of mental illness and the tragedy of suicide, medical providers report they have not been adequately trained to recognize or treat mental health problems.[6]

The training implemented through this project will be provided by ATCIC mental health professionals who are certified as instructors. As the local mental health authority, ATCIC serves a vital role in educating the public about mental illnesses, suicide prevention, and how to link individuals to needed services.

Since 1966, ATCIC has served children, families, and adults with behavioral health disorders. ATCIC is the local mental health authority for Travis County and carries its mission through funding from a variety of grants and local, state and federal sources. ATCIC is Joint Commission accredited and provides the following services: behavioral health to adults with Serious Mental Illness (SMI) and children with serious emotional Disturbance (SED), intellectual and developmental disabilities (IDD), and psychiatric crisis services. In fiscal year 2011, ATCIC served more than 22,000 individuals and families.

Project Goals

The goal for the Mental Health First Aid (MHFA) and Recognizing and Responding to Suicide Risk in Primary Care (RRSP-PC) is to increase the mental health and suicide prevention knowledge, skills of primary care staff through the provision of evidence-based training. More specifically, the five-year target goals are to provide evidence-based training to at least 1,350 primary care staff to identify the signs and symptoms of mental illness, assist those experiencing a mental health crisis and/or suicidal and link individuals in need to appropriate professional help care through increased referrals to integrated health care within the primary care setting, expanded behavioral health outpatient services, mobile crisis outreach, or psychiatric emergency services.

During DSRIP Year (DY) 2, the project goals include completing an assessment of primary care staff needs and interest in trainings as well as their pre-test knowledge and satisfaction. Through DY's 3, 4, and 5, the project will implement trainings of primary staff and improve their knowledge in mental health and suicide prevention competency.

Challenges or Issues Faced by the Performing Provider – Although prevalence research indicates that 26.2 percent of adults in the US are diagnosed with a mental illness in any given year, there is a lack of public awareness, which leads to stigma and fear.[7] Among primary care staff, their lack of pre-professional training and knowledge related to mental illness and suicide may contribute to apprehension and resistance in dealing with their patients' mental health issues. Moreover, their lack of skills on how to help patients in crisis or how to deal with their possible suicidal ideation may make them resistant to assessing the mental health problems and reluctant to participate in training designed to target mental illness and suicide.

Additional challenges to project implementation may be the demands of primary health care settings and the minimal time available for staff to receive training outside normal clinic operations.

How the Project Addresses those Challenges – The project addresses those challenges through assertive outreach and engagement of primary care administration and staff. For example, primary care staff already certified in MHFA, will partner with the ATCIC training team to promote the benefits and emphasize the need for MHFA and suicide prevention knowledge and skills to enhance patient care. In FY

2011, primary care staff from ATCIC's integrated health program was certified in MHFA and have since served as champions in recruiting healthcare staff from other settings to obtain the training.

Logistical and time restraints for staff training will be addressed by offering on-site trainings in flexible time increments. For example, the 12 hour MHFA training can be provided in four three hour segments.

Finally, Continuing Education Units (CEUs) will be offered for all trainings as an added incentive to participation. MHFA offers 12 hours of CEUs and the suicide prevention training offers one and a half.

How the Project is Related to RHP Goals- The six counties that comprise RHP Region 7 in Texas have identified seven RHP goals, of which, the following five relate to this project:

1. Preparing and developing infrastructure to improve the health of the current and future Region 7 populations.
2. Improve patient experience of care by investing in patient-centered, integrated and comprehensive care that is coordinated across systems.
3. Prevention education to improve population health and patient experience by increasing the quality of care and patient safety.

Starting Point/Baseline

Baseline Data- To date, ATCIC has certified over 600 people representing over 60 organizations in Mental Health First Aid and Suicide Prevention throughout Travis County. Since ATCIC began providing MHFA training in 2009, it has certified a variety of key professionals and members of the community, including: school personnel, educators, nurses, emergency department social workers, security personnel, City of Austin library staff, direct service staff in behavioral health care settings, supportive housing personnel, volunteers and the general public. Less than five percent of those trained to date work in primary care settings.

Presently none of the 1,350 primary care staff serving over 100,000 patients with behavioral healthcare needs, 62% of whom are Medicaid eligible or indigent, have been trained in mental health and suicide prevention. This will be the baseline data used for improvements.

Time Period for Baseline: Baseline data will be collected during DY 2.

Rationale

Reason for Selection of Project Options and Components – Current training for primary care staff is insufficient to adequately serve the highly prevalent behavioral health needs of patients. One out of every two patients seen by primary care staff have a co-occurring mental illness. Without adequate training to recognize behavioral health problems among patients and to manage mental health crises including suicidal risk, patients' critical needs go unmet. Primary care staff are aware of their lack of training and report that they are unprepared to meet the behavioral health needs of their patients. With suicide as the 8th leading cause of death in Travis County, failure to recognize and treat suicide risk could result in loss of life

MHFA is an evidence-based curriculum proven to help individuals recognize the signs and symptoms of mental illness, effectively intervene to assist individuals in crisis, and make appropriate referrals to mental health professionals (which may reduce unnecessary contacts with law enforcement). Suicide is a complex,

but highly preventable public health problem. Recently released national guidelines for clinical care settings have been established based on dramatic successes achieved throughout the country in reducing suicide deaths, attempts and costs associated with unnecessary hospital and emergency department care. Most importantly, these suicide prevention initiatives save lives. As a public education program, MHFA has the potential to educate communities, improve mental health literacy and empower individuals.

Since its inception at the University of Melbourne in 2001, MHFA has undergone several studies to examine its effectiveness.[8] Findings revealed those participants:

- Learned how to recognize mental disorders,
- Better understood mental health treatments,
- Were more confident in providing help to others,
- Improved mental health for themselves,
- Were more comfortable around people with mental disorders, and
- Were more likely to provide help to others and seek guidance for professional help as needed

RRSR-PC is an evidence-based curriculum offered through the American Association of Suicidology. It is designed to teach primary care practitioners and staff best practices in assessing for suicide risk and providing appropriate assistance to distressed patients. The training also provides guidance to primary care staff in working collaboratively with patients to create treatment plans.

Reason for Selection of Milestones & Metrics - Process Milestone/metric P-1 was selected to establish the number of primary care staff interested and in need of mental health first aid and suicide prevention training. This process measure was further chosen to assess staffs' pre-test knowledge. In addition process milestone/metric P-2 was selected to deliver the necessary trainings for primary care staff throughout the community.

Unique Community Need Identification Number: CN.4, CN.6, CN.7, CN.15

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:. Less than five percent of the 600 individuals trained in ATCIC's MHFA program work in primary care settings. The proposed project represents a new initiative to target MHFA and suicide prevention training to primary care staff.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS): None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected IT9.2: ED Utilization One Category 3 standalone improvement target will be implemented for this project under the category outcome reduce Emergency Department visits over baseline

Reasons/Rationale for Selecting the Outcome Measure(s) - As referenced in the Community Needs Assessment, Region 7 has inadequate access to behavioral healthcare. Stigma, which serves as a barrier to access, and lack of coordinated care will be addressed by educating primary care staff. Primary care staff who feel empowered and confident about their mental health literacy and suicide prevention skills are expected to utilize these skills in their everyday work. The satisfaction measure will help gauge their self-perceived abilities on this topic.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects:

List of Related Category 1 & 2 Projects *(RHP Project ID Number):* 133542405.2.1, 133542405.2.2, 01335424-05.2.14.1

List of Related Category 4 Projects *(RHP Project ID Number)*: N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects
186599001.1.1: School Campus Counseling
133340307.2.4: Trauma Informed Care
133340307.2.7: Children's Trauma Informed Care
201320302.2.1: Provide ACT Model for Participants of HF PSH
137265806.2.3: Substance Abuse Disorder Navigation
137265806.2.4: Behavioral Health Assessment and Resource Navigation

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects – Region-wide, anchor-led meetings will be held at least semi-annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project – The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and cost reduction to the healthcare system. In considering the incentive portion of the valuation, three principles and their subsequent impacts were considered. These principles include: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. By training primary care staff to identify, treat, or refer patients to appropriate specialty behavioral healthcare, patients are less likely to use ED's for their psychiatric needs.

Calculating the value of interventions for this project for a specialty behavioral health population was done using an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness

thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often frequent users of the healthcare system. These individuals also frequently present with a number of functional impairments, which lead to involvement in the criminal justice system. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare and criminal justice systems.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website atIntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

References

1. National Institute of Mental Health (2011)www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml
2. Pirl, W.F.; Beck, B.J.; Safren, S. A.; Kim, H (2001). "A descriptive study of psychiatric consultations in a community primary care center". *Primary Care Companion Journal of Clinical Psychiatry* **3** (5): 190–194. doi:10.4088/PCC.v03n0501
3. National Center for Injury Prevention and Control (2007) Suicide facts at a glance. Centers for Disease Control and Prevention. Atlanta, GA.
4. Austin Travis County Health and Human Services (2012). Critical Indicators Report.
5. Austin Travis County Integral Care (2012) 2011 Annual Suicide Report: deaths By Suicide in the City of Austin
6. Hogg Foundation for Mental Health (May 23, 2008) Health care in Texas: Critical workforce shortage in mental health. www.hogg.utexas.edu/uploads/documents/mhwkfrc-shortage-052308.pdf
7. Kessler, R.C., Chiu, W.T., Demler, O. and Walters, E.E. (2005) Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry.62, 617-627.
8. Kitchener, B.A, Jorm, A.F., and Kelly, C.M., Maryland Department of Health and Mental Hygiene, Missouri Department of Health, and the National Council for Community Behavioral Healthcare (2009) Mental Health First Aid USA.

133542405.1.1	1.2.5	1.2.5	***Mental Health First Aid and Suicide Prevention***
Austin Travis County Integral Care			***133542405***
Related Category 3 Outcome Measure(s):	133542405.3.4	IT-9.2	***Reduce Emergency Department visits for behavioral health 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-X1 Develop implementation plan/timeline Metric 1 P-X1.1: Training plan and delivery process are documented Goal: Complete timeline and plan Data Source: Project Documentation Milestone 1 Estimated Incentive Payment **$223,191** **Milestone 2 P-X2** Identify primary care staff to be trained Metric 2 P-X2.1: Number of individuals meeting criteria Goal: Schedule trainings for DY3 Data Source: Project records Milestone 2 Estimated Incentive Payment **$223,191**	**Milestone 3 P-X3** Hire staff Metric 1 PX3.1: Number of staff hired Goal: Hire all staff Data Source: Project Personnel Records Milestone 3 Estimated Incentive Payment: **$122,546** **Milestone 4 P-X4:** Train staff in required knowledge skills and abilities Metric 1: P-X4.14 Number of staff trained Goal: Train all hired staff Data Source: Project training records/ curricula Milestone 4 Estimated Incentive Payment: **$122,546** **Milestone-** PX5 Conduct a primary care training gap analysis to determine training needs	**Milestone 7 I-X7** Increase number of trainings for primary care staff Metric PX 7.1 Number of staff trained Goal: Train 450 primary care staff Data Source: Project database documentation Milestone **7** Estimated Incentive Payment: **$174,794** **Milestone 8** IX8 Evaluate and continuously improve delivery of trainings Metric 1:X8.1 Plan documentation demonstrates use of PDSA QI process Goal: Identify improvement needs Data Source: Project reports use of course evaluations Milestone **8** Estimated Incentive Payment: **$174,794** **Milestone 9**:1-11 Increase training of primary care staff	**Milestone 10 -X1 0** Increase number of trainings for primary care staff Metric PX10. Number of staff trained Goal: Train 600 primary care staff additional enrollees Data Source: EMR and project database documentation **Milestone10** Estimated Incentive Payment: **$168,883** **Milestone 11** I-X11 Participate in 2x yearly meetings with primary care providers to share and promote learning about project experience Metric IX11. P-X Documented meeting participation Goal: participate in 2 meetings Data Source: Agendas, minutes, meeting notes Milestone **9** Estimated Incentive Payment: **$168,883**

133542405.1.1	1.2.5	1.2.5	***Mental Health First Aid and Suicide Prevention***
Austin Travis County Integral Care			***133542405***
Related Category 3 Outcome Measure(s):	133542405.3.4	IT-9.2	***Reduce Emergency Department visits for behavioral health 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)**
	Metric PX5.1 P-1.1: Gap assessment of training needs Goal: Targeted training plan Data Source: Project Documentation **Milestone 5** Estimated Incentive Payment: **$122,546** **Milestone 6: IX6** Train 300 individuals in MHFA and/or suicide prevention Metric IX6 1: Number of individuals trained Goal: Train 300 primary care staff Data Source: Project Documentation **Milestone 6** Estimated Incentive Payment: **$122,546**	Metric 1:9.1-11.6 Improvement in knowledge assessment scores Goal: Improved knowledge Data Source: Project Documentation **Milestone 9** Estimated Incentive Payment $**174,794**	**Milestone 12:1-1 Increase training of primary care staff** Metric 1:12-11.6 Improvement in knowledge assessment scores Goal: Improved knowledge Data Source: Project Documentation **Milestone 12**Estimated Incentive Payment **$168,884**
Year 2 Estimated Milestone Bundle Amount*:* **$446,382**	Year 3 Estimated Milestone Bundle Amount: **$490,184**	Year 4 Estimated Milestone Bundle Amount: **$524,383**	Year 5 Estimated Milestone Bundle Amount: **$506,650**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,967,599			

Austin Travis County Integral Care
Expand Specialty Behavioral Healthcare Prescriber Capacity
Project Identifier - 133542405.1.2 Pass 2

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has served as the local mental health authority for Travis County. ATCIC is Joint Commission accredited and the only dedicated outpatient specialty behavioral health provider in Austin that serves adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

Intervention(s): This project is will increase access and capacity to behavioral healthcare for the safety-net population by adding behavioral health prescribers in four outpatient clinic settings at key service points. Two prescribers will provide services at ATCIC's two outpatient clinics that serve adults with SMI. A third prescriber will provide services at Psychiatric Emergency Services (PES) to individuals experiencing a psychiatric crisis. The fourth prescriber will be located at CommUnityCare's healthcare for the homeless clinic to provide this vital service for the most vulnerable population in our community.

Need for the project: Psychiatric Emergency Services (PES) is a walk-in psychiatric emergency clinic open 24/7. PES is presently funded for only one full-time psychiatrist. In FY 2012, ATCIC served 7,500 unduplicated adults with SMI at two outpatient clinic locations. Staff psychiatrists have caseloads exceeding 700 enrolled adults. These capacity limitations delay access to an initial psychiatric evaluation and treatment for adults with SMI seeking services an average of 90-120 days or more. CommUnityCare is the largest and most comprehensive primary care safety-net provider in Travis County, operating 22 clinics including Austin Resource Center for the Homeless (ARCH). In 2011, more than 1,207 adults received services at the ARCH. Approximately 17 percent also received behavioral health services. Psychiatric services at the ARCH are limited to 16 hours per month, which resulting in delays greater than of 30 days or greater for psychiatric evaluation.

Target population: This target population is for adults with SMI who need outpatient psychiatric services. ATCIC contracts with the Texas Department of State Health Services to provide specialty behavioral health services for people below 200 percent of the Federal Poverty Level. Currently, approximately 38 percent of individuals served by ATCIC have Medicaid and/or Medicare. All other individuals served are funded through state general revenue funds received from the Department of State Health Services.

Category 1 or 2 expected patient benefits: The baseline number of duplicated encounters to be provided by these four prescribers is 3,300 individuals. This baseline purposely reflects duplicated encounters due to the fact that ATCIC's PES site serves individuals who are new to our clinic system as well as established patients experiencing a psychiatric crisis. The project seeks to increase the number of adult consumers accessing psychiatric and other behavioral health services by five percent in DY 3, 10 percent in DY 4 and 15 percent in DY 5 after establishing baselines.

Category 3 outcomes: OD-1: Primary Care and Chronic Disease Management. IT-1.18 - Follow-up after hospitalization for mental illness.

Title of Project: **Expand Specialty Behavioral Healthcare Prescriber Capacity**

Category / Project Area / Project Option: **1.9.3**

RHP Project Identification Number: **133542405.1.2 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description - This proposed project addresses a need in Travis County to increase the capacity and access to behavioral health prescribers serving the safety net population in outpatient clinic settings. Austin Travis County Integral Care (ATCIC) will embed one prescriber in each of its two adult services outpatient clinics and one prescriber at its Psychiatric Emergency Services (PES) site. ATCIC will also employ one additional prescriber for its integrated behavioral health services program with its local federally qualified health (FQHC) clinic partner, CommUnityCare. In the past 10 years, ATCIC has gained considerable experience in providing integrated behavioral health services in primary care clinics with CommUnityCare. This additional prescriber will be embedded within the CommUnityCare's primary care clinic located in the Austin Resource Center for the Homeless (ARCH).

Since 1966, ATCIC has served as the local mental health authority for Travis County. ATCIC is Joint Commission accredited and the only dedicated outpatient specialty behavioral health provider in Austin that serves adults with serious mental illness (SMI) and children with Serious Emotional Disturbance (SED). ATCIC contracts with the Texas Department of State Health Services to provide specialty behavioral health services to people below 200 percent of the Federal Poverty Level (FPL). Currently, approximately 38 percent of individuals served by ATCIC have Medicaid and/or Medicare. All other individuals served are funded through state general revenue funds received from the Department of State Health Services.

In fiscal year (FY) 2012, ATCIC served 7,500 unduplicated adults with SMI at its two outpatient clinic locations. The first clinic site, Psychiatric & Counseling Services, served 5,801 (77%) adults with the second site, North Services Center, serving 1,699 (23%) adults. Staff psychiatrists currently have caseloads exceeding 700 enrolled adults. ATCIC's chief medical officer has determined that the optimal caseload size for adults with SMI is 500 individuals. These capacity limitations delay access to an initial psychiatric evaluation and treatment for adults with SMI seeking services to 90-120 days or more. Such obstacles to accessible treatment can result in delayed care or individuals seeking treatment at medical hospital emergency departments (EDs) and/or PES, the most expensive points of service in our systems.

PES is a walk-in psychiatric emergency clinic open 24 hours a day, seven days a week, for anyone experiencing psychiatric distress. It is staffed by licensed clinicians (clinical social workers and counselors), psychiatrists, nurses and qualified mental health professionals who provide crisis services that include psychiatric assessments, crisis intervention and linkage to community resources. PES assists with triaging client care through other ATCIC programs, local EDs, the Austin Police Department's (APD) Crisis Intervention Team (CIT) and the Travis County Sheriff's Office. In FY 2012, PES served 6,127 duplicated

adults. PES is presently funded for only one full-time psychiatrist. Although PES is open 24 hours per day, psychiatric coverage on site is limited to the hours of 8AM-5PM, Monday through Friday. This resource limitation results in individuals again seeking care in hospital EDs and/or being hospitalized to secure psychiatric care and medications.

CommUnityCare is the largest and most comprehensive primary care service provider for the safety-net population in Travis County. CommUnityCare operates 22 clinic locations providing over 220,000 medical and dental appointments each year. This number represents more than 62,000 individual patients. ATCIC has partnered with CommUniyCare for more than 10 years to provide embedded integrated behavioral health services through the primary care clinics. Since 2004, CommUnityCare has provided healthcare for homeless individuals through the ARCH. In 2011, over 1,207 adults received services at this clinic, of which approximately 17 percent also received behavioral health services. Psychiatric services at the ARCH are limited to sixteen 16 hours per month. This resource limitation results in a delay of over 30 days for individuals to receive a psychiatric evaluation. "Specific populations within Region 7 require unique consideration for healthcare services. Among Central Health's Medical Access Program, homeless persons have higher utilization across all types of care, particularly emergency and inpatient psychiatric services. Approximately 21% of homeless people are considered to be severely mentally ill, and 33% have a chronic substance abuse disorder" (RHP-7, Community Needs Assessment, September 2012).

Project Goals - - The goal of this project is to increase access and capacity by providing behavioral health prescribers in three outpatient clinic settings in Travis County. Four psychiatric providers will be placed at key service points serving the safety-net population. One prescriber will provide services at one of ATCIC's outpatient clinics that serve adults with SMI. Two prescribers will provide services at PES to individuals experiencing a psychiatric crisis. The fourth prescriber will be located at CommUnityCare's healthcare for the homeless clinic to provide this vital service for the most vulnerable population in our community.

The baseline number of duplicated encounters to be provided by these four prescribers is 3,300 individuals. This baseline purposely reflects duplicated encounters due to the fact that ATCIC's PES site serves individuals who are new to our clinic system as well as established patients experiencing a psychiatric crisis. The goal during four years is to increase the number of adult consumers who access psychiatric and other behavioral health services by five percent in DSRIP Year (DY) 3, 10 percent in DY 4 and 15 percent in DY 5 over baseline established in DY-2.

Challenges or Issues Faced by the Performing Provider

1. Timely recruitment of psychiatric providers for community psychiatry services is an anticipated challenge. A study published by the Hogg Foundation for Mental Health in March 2011 states that out of the four most populous states in the United States, Texas has the most severe shortage of psychiatrists and mental health professionals.
http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf

2. The education and training of the psychiatric provider to be located the integrated care setting at ARCH is a second challenge. Traditional medical practices and training approach the provision of primary care medicine and psychiatric medicine as distinctly separate.

How the Project Addresses those Challenges

1. ATCIC will engage a medical professional recruitment company to seek the most qualified psychiatric providers both in Texas and nationally to facilitate timely recruitment of prescriber staff. In addition,

ATCIC's chief medical officer will work with psychiatric training programs in Texas as another strategy to recruit qualified candidates.

2. In the past 10 years, ATCIC has gained experience working with FQHC partner CommUnityCare, to facilitate the education and training of medical providers in an integrated care approach. This will be essential for the psychiatric provider that will be co-located with the primary care team at the ARCH.

How the Project is Related to RHP Goals

The six counties that comprise RHP Region 7 in Texas have identified seven RHP goals, of which, the following three relate to this project:

1. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
2. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
3. Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data – ATCIC served over 7,500 unduplicated adults in FY 2012 at two outpatient clinics and over 6,127 duplicated adults at PES. Approximately 210 patients received integrated behavioral health services through the healthcare for the homeless clinic at the ARCH. However, because this project proposes the addition of four prescribers to augment outpatient behavioral health services, a baseline must be determined for their service delivery.

Time Period for Baseline – Baseline will be established in DY 2

Rationale

Reason for Selection of Project Options and Components - This "other" project option was selected as it represents the flexibility and innovation needed in embedding psychiatric prescribers in three distinct outpatient clinical settings: specialty behavioral health, psychiatric emergency services and primary healthcare for the homeless clinic.

Reason for Selection of Milestones & Metrics - Process milestone/metric P-3 and improvement milestone/metric I-23 were selected as they are consistent with the RHP-7 goals of: 1. Expanding access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery, and 2. Increasing specialty care services access and volume of visits for patients seeking behavioral health services.

Unique Community Need Identification Number – CN.2, CN.4, CN.6, CN.16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative - Although ATCIC has extensive experience providing outpatient specialty behavioral health, psychiatric emergency and integrated behavioral health services, this project will increase prescriber capacity to provide individuals with the right care at the right time and in the right setting.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) - None

Related Category 3 Outcome Measure(s)

Category 3* Outcome *Measures(s) Selected – OD-1: Primary Care and Chronic Disease Management. The Category 3 standalone improvement target to be implemented for this project is IT-1.18 - Follow-up after hospitalization for mental illness.

Reasons/Rationale for Selecting the Outcome Measure(s) – The CNA reveals that Travis County experienced a 33 percent increase in inpatient psychiatric hospitalizations from 2008 to 2010. In Travis County, suicides are the eighth leading cause of death and the fourth leading preventable cause of death. Research indicates that the weeks after discharge represents a critical period for suicide risk. (Hunt et al. Psychological Medicine (2009). 39, 443-449). The addition of four psychiatric prescribers in ATCIC's two outpatient clinics and PES will assist people to receive timely follow-up care post psychiatric hospitalization.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects - TBD

List of Related Category 1 & 2 Projects *(RHP Project ID Number)* - 133542405.2.1, 133542405.2.2, 133542405.1.7

List of Related Category 4 Projects *(RHP Project ID Number)* - N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

201320302.2.1: Provide ACT Model for Participants of HF PSH
307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
137265806.1.2: Expand Psychiatric Residency Programs

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Outcome Measure
The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts

were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. These psychiatric providers will be deployed to ATCIC's Psychiatric Emergency Services site, at a primary care clinic site provided healthcare individuals who are homeless through CommUnityCare, and at ATCIC's two adult outpatient clinic sites.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.1.2	1.9	1.9.3	Expand Specialty Behavioral Healthcare Provider Capacity
Austin Travis County Integral Care			133542405
Related Category 3 Outcome Measure(s):	133542405.3.5	IT-1.18	Follow-Up After Hospitalization for Mental Illness

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]: Establish baseline for performance indicators Baseline/Goal: 3,300 (duplicated) Data Source: EHR, project data Milestone 1 Estimated Incentive Payment: $2,427,321	**Milestone 2** [I-23]: Increase specialty care clinic volume of visits and evidence improved access for patients seeking services Metric 1 [I-23.1]: Documentation of increased number of visits. Goal: Demonstrate 5% improvement over DY2 baseline Data Source: EHR, project data Milestone 2 Estimated Incentive Payment: $2,665,500	**Milestone 3** [I-23]: Increase specialty care clinic volume of visits and evidence improved access for patients seeking services Metric 1 [I-23.1]: Documentation of increased number of visits. Goal: Demonstrate 10% improvement over DY2 baseline Data Source: EHR, project data Milestone 3 Estimated Incentive Payment: $2,851,476	**Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence improved access for patients seeking services Metric 1 [I-23.1]: Documentation of increased number of visits. Goal: Demonstrate 15% improvement over DY2 baseline Data Source: EHR, project data Milestone 4 Estimated Incentive Payment: $2,755,044
Year 2 Estimated Milestone Bundle Amount: $2,427,321	Year 3 Estimated Milestone Bundle Amount: $2,665,500	Year 4 Estimated Milestone Bundle Amount: $2,851,476	Year 5 Estimated Milestone Bundle Amount: $2,755,044
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $10,699,341			

Austin Travis County Integral Care
Introduce, Expand, or Enhance Telemedicine/Telehealth
Project Identifier - 133542405.1.3 Pass 2

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has served as the local mental health authority for Travis County. ATCIC is Joint Commission accredited and the only dedicated outpatient specialty behavioral health provider in Austin that serves adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

Intervention(s): This project addresses the need in Travis County to increase capacity and access to specialty behavioral health psychiatric assessment and medication services for the safety-net population. ATCIC will augment its existing psychiatric services by contracting with a psychiatric telemedicine provider experienced in the assessment and treatment of adults with SMI. ATCIC will initially deploy this service at its Psychiatric Emergency Services (PES) site and its two adult outpatient clinic sites.

Need for the project: PES is a walk-in psychiatric emergency clinic open 24/7 for anyone experiencing psychiatric distress. PES is presently funded for only one full-time psychiatrist. In FY 2012, ATCIC served 7,500 unduplicated adults with SMI at two outpatient clinic locations. Staff psychiatrists currently have caseloads exceeding 700 enrolled adults. ATCIC's chief medical officer has determined that the optimal caseload size for adults with SMI is 500 individuals. These capacity limitations delay access to an initial psychiatric evaluation and treatment for adults with SMI seeking services an average of 90-120 days or more. Such obstacles to accessible treatment can result in delayed care or individuals seeking treatment at hospital EDs and/or PES, the most expensive points of service in our systems.

Target population: ATCIC contracts with the Texas Department of State Health Services to provide specialty behavioral health services for adults with SMI and children/youth with SED who are below 200 percent of the Federal Poverty Level. Currently, approximately 38 percent of individuals served by ATCIC have Medicaid and/or Medicare. All other individuals served are funded through state general revenue funds received from the Department of State Health Services.

Category 1 or 2 expected patient benefits: The baseline number of duplicated encounters for patients needing a psychiatric evaluation telemedicine is expected to be 1,000 individuals. This baseline purposely reflects duplicated encounters due to the fact that ATCIC's PES serves individuals who are new to our clinic system as well as established patients experiencing a psychiatric crisis. The project seeks to increase the number of adult consumers who access psychiatric telemedicine services by five percent in DSRIP DY 3, 10 percent in DY 4 and 15 percent in DY 5 over baseline. The baseline will be established in DY 2 as ATCIC has not previously provided this service.

Category 3 outcomes: IT-6.1 Percent Improvement over baseline of patient satisfaction scores utilizing Press-Ganey measurement strategies and tools. This measure was selected to ensure that implementation of this new service meets patient needs for timely and quality care.

Title of Project: **Introduce, Expand, or Enhance Telemedicine/Telehealth**

Category / Project Area / Project Option: **1.7.1**

RHP Project Identification Number: **133542405.1.3 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description - This project addresses the need in Travis County to increase capacity and access to specialty behavioral health psychiatric assessment and medication services for the safety-net population. To accomplish this goal, Austin Travis County Integral Care (ATCIC) will augment its existing psychiatric services by contracting with a psychiatric telemedicine provider experienced in the assessment and treatment of adults with serious mental illness (SMI). ATCIC will initially deploy this service at its Psychiatric Emergency Services (PES) site and its two adult outpatient clinic sites to ensure that adults with SMI receive the right service at the right time and in the right setting.

Since 1966, Austin Travis County Integral Care (ATCIC) has served as the local mental health authority for Travis County. ATCIC is Joint Commission accredited and the only dedicated outpatient specialty behavioral health provider in Austin that serves adults with serious mental illness (SMI) and children with Serious Emotional Disturbance (SED). ATCIC contracts with the Texas Department of State Health Services to provide specialty behavioral health services to people below 200 percent of the Federal Poverty Level (FPL). Currently, approximately 38 percent of individuals served by ATCIC have Medicaid and/or Medicare. All other individuals served are funded through state general revenue funds received from the Department of State Health Services.

PES is a walk-in psychiatric emergency clinic open 24 hours a day, seven days a week, for anyone experiencing psychiatric distress. PES is presently funded for only one full-time psychiatrist. Additional staff includes licensed clinicians (clinical social workers and counselors), nurses and qualified mental health professionals providing crisis services such as psychiatric assessments, crisis intervention and linkage to community resources. PES assists with triaging consumer care through other ATCIC programs, local emergency departments (EDs), Austin Police Department's (APD) Crisis Intervention Team (CIT) and the Travis County Sheriff's Office. In FY 2012, ATCIC's PES served 6,127 duplicated adults.

In FY 2012, ATCIC served 7,500 unduplicated adults with SMI at two outpatient clinic locations. The first clinic site, Psychiatric and Counseling Services served 5,801 (77%) adults and the second site, North Services Center, served 1,699 (23%). Staff psychiatrists currently have caseloads exceeding 700 enrolled adults. ATCIC's chief medical officer has determined that the optimal caseload size for adults with SMI is 500 individuals. These capacity limitations delay access to an initial psychiatric evaluation and treatment for adults with SMI seeking services to 90-120 days or more. Such obstacles to accessible treatment can result

in delayed care or individuals seeking treatment at hospital EDs and/or ATCIC's PES, the most expensive points of service in our systems.

Project Goals - The goal of this project is to increase access and capacity to psychiatric assessments and medication services for the safety-net population in Travis County through deployment of psychiatric telemedicine services at three ATCIC outpatient clinic sites. The PES clinic will have psychiatric telemedicine services accessible after hours Monday through Friday and 24-hours per day on Saturday and Sunday. ATCIC's two outpatient clinics, Psychiatric and Counseling Services and the North Services Center, will also use telemedicine services for individuals needing immediate evaluation and/or medication management services to ensure the right care at the right time and in the right setting.

The baseline number of duplicated encounters for patients needing a psychiatric evaluation telemedicine is expected to be 1,000 individuals. This baseline purposely reflects duplicated encounters due to the fact that ATCIC's PES serves individuals who are new to our clinic system as well as established patients experiencing a psychiatric crisis. The goal throughout four years is to increase the number of adult consumers who access psychiatric telemedicine services by five percent in DSRIP DY 3, 10 percent in DY 4 and 15 percent in DY 5 over baseline established in DY-2.

Challenges or Issues Faced by the Performing Provider
The principal challenge to be faced by ATCIC consumers and staff rests with the implementation of a new or novel approach to psychiatric medicine service delivery in our practice.

How the Project Addresses those Challenges
ATCIC will engage and consult with Bluebonnet Trails Community Services community center, one of our RHP-7 specialty behavioral health services partners. Bluebonnet Trails has been utilizing psychiatric telemedicine for a number of years. Consultation will include strategies for: consumer engagement; education and informing the community about this service delivery approach; and training ATCIC staff.

How the Project is Related to RHP Goals
The six counties that comprise RHP Region 7 in Texas have identified seven RHP goals. This project will address two of these goals:

1. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

2. Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data – ATCIC has not provided or engaged a provider of telemedicine services in the past. A baseline will be established.

Time Period for Baseline – Baseline will be established in DY 2

Rationale

Reason for Selection of Project Options and Components – One of the identified needs in the RHP-7 Community Needs Assessment individuals with behavioral health conditions pointed to a need for screening, outpatient treatment and integrated care. To ensure that individuals needing access to specialty behavioral health services receive the right service at the right time and in the right setting this project option was selected to ensure: 1) access to and provision of psychiatric telemedicine services; and 2) conducting quality improvement strategies such as rapid cycle improvements to ensure ATCIC's safety-net consumers receive the maximum benefit from this innovative service.

Reason for Selection of Milestones & Metrics - Process milestone P-3 and improvement milestone I-12 were selected for this project as they are consistent with the RHP-7 goal 6 of expanding access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Unique Community Need Identification Number - CN.2, CN.4, CN.6, CN.16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative – Although ATCIC has extensive experience in providing specialty behavioral health care services to adults with SMI, this effort represents a new and innovative initiative for our consumers and practice.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) – N/A

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected – OD-6: Patient Satisfaction, IT-6.1 Percent Improvement over baseline of patient satisfaction scores utilizing Press-Ganey measurement strategies and tools.

Reasons/Rationale for Selecting the Outcome Measure(s) - This measure was selected to ensure that implementation of this new service meets the needs for timely and quality care.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects - TBD

List of Related Category 1 & 2 Projects *(RHP Project ID Number)* - 133542405.2.1, 133542405.2.2, 133542405.2.3

List of Related Category 4 Projects *(RHP Project ID Number)* – N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects - TBD

133340307.2.3: Co-occurring Psychiatric and Substance Use Disorder
133340307.1.1: Hays County Mental Health Center Mobile Clinic
133340307.2.12: Hays County Virtual Psychiatric and Clinical Guidance
201320302.2.1: Provide ACT Model for Participants of HF PSH
307459301.1.8: Telepsychiatry in Federally Qualified Primary Health Clinics
137265806.1.1: Psychiatric Emergency Department
137265806.1.3: Psychiatric Telemedicine for Emergency Services

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Outcome Measure

The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. This psychiatric telemedicine service will be deployed to ATCIC's Psychiatric Emergency Services site and at ATCIC's two adult outpatient clinic sites.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis

to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com

The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.1.3	1.7	1.7.1	Introduce, Expand, or Enhance Telemedicine/Telehealth	
Austin Travis County Integral Care				133542405
Related Category 3 Outcome Measure(s):	133542405.3.6	IT-6.1	Percent Improvement over baseline of patient satisfaction scores	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3] Implement or expand telemedicine program for selected medical (psychiatric) specialty, based upon regional and community need. Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents Baseline/Goal: Submission of implementation documentation Data Source: Program materials Metric 2 [P-3.2]: Documentation of the number of psychiatric consultations delivered Baseline/Goal: 1000 encounters (duplicated) Data Source: EHR Milestone 1 Estimated Incentive Payment: $317,781	**Milestone 2** [I-12]: Increase the number of telemedicine visits for psychiatric specialty identified as high need Metric 1 [I-12.1]: Number of telemedicine visits Goal: 5% increase in number of telemedicine visits over baseline established in DY-2 Data Source: EHR, project data Milestone 2 Estimated Incentive Payment: $348,964	**Milestone 3** [I-12]: Increase the number of telemedicine visits for psychiatric specialty identified as high need Metric 1 [I-12.1]: Number of telemedicine visits Goal: 10% increase in number of telemedicine visits over baseline established in DY-2 Data Source: EHR, project data Milestone 3 Estimated Incentive Payment: $373,311	**Milestone 4** [I-12]: Increase the number of telemedicine visits for psychiatric specialty identified as high need Metric 1 [I-12.1]: Number of telemedicine visits Goal: 15% increase in number of telemedicine visits over baseline established in DY-2 Data Source: EHR, project data Milestone 4 Estimated Incentive Payment: $360,687
Year 2 Estimated Milestone Bundle Amount: $317,781	Year 3 Estimated Milestone Bundle Amount: $348,964	Year 4 Estimated Milestone Bundle Amount: $373,311	Year 5 Estimated Milestone Bundle Amount: $360,687

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,400,743

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba
Bluebonnet Trails Community Services
Category 1 DSRIP Projects

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Youth Counseling for Fayette and Lee Counties
126844305.1.1 Pass 1

Provider: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7. As the LMHA, we contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Serious Emotional Disturbance. BTCS is the only provider of public behavioral health services in Fayette and Lee Counties.

Intervention(s): BTCS proposes to develop counseling and early intervention services that are delivered at school campuses in collaboration with the school districts in Fayette and Lee Counties. We will add four licensed counselors with experience and training in short term solution focused counseling.

Need for the project: The school staff has requested these services in order to increase access for all children and specialty services for those with more intense needs. The school representatives and Mental Health Task Force members identified the issue that schools are experiencing a higher demand for counseling in schools than they have capacity to address. The problem in these Counties is that there are more counseling needs than resources and that the acuity of the needs is frequently beyond the experience and capabilities of most of the school counselors. This project addresses RHP 7 Community Needs Assessment needs: CN.4 – Inadequate access to behavioral health care; CN.5 - rural transportation issues; and CN.16 – Lack of services for children.

Target population: The target population is youth with intense needs who are identified in school or and referred by Juvenile Probation Departments. We expect to provide direct services in this project to 75 youth in DY 4 and 100 youth in DY 5 and in so doing free school counselors to better serve those needing less intense counseling. BTCS served 1,292 youth in its 8 County region in FY 2012, 76% of the youth were eligible for CHIP or Medicaid. We expect over 80% of those benefitting from these services will be uninsured or enrolled in CHIP or Medicaid.

Category 1 or 2 expected patient benefits: Youth and families will be able to participate in counseling locally which increases access to the service and prevents further deterioration and utilization of higher levels of care. This project will seek to serve 75 youth in DY 4 and 100 youth in DY5. Currently the only resources are in Austin and travel and acceptance into counseling services is a barrier to the poor and under and uninsured. No intensive school based services exist in these Counties DY 2, therefore the baseline is 0.
Category 3 outcomes: IT- 6.1 By providing this service locally, we expect satisfaction to be high at the outset. Our goal is to demonstrate a 10% improvement in satisfaction scores for timely care, involvement in decision making and overall health/functional status over baseline in DY 4 and 15% in DY 5.

Title of Project: **Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Youth Counseling for Fayette and Lee Counties**

Project Option: **1.12.2**

RHP Project Identification Number: **126844305.1.1 Pass 1**

Performing Provider Name: **Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services**

Performing Provider TPI: **126844305**

Project Description

Overall Project Description

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7. As the LMHA, we contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Serious Emotional Disturbance (SED), which DSHS identifies as a "priority population" for the LMHA. The Federal Definition for youth diagnosed with SED can be found at http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc . These youth are generally having adjustment or functioning difficulties in more than one life domain and therefore are usually served by more than one child serving agency in the community including specialized school programs, Juvenile Probation and the LMHA. BTCS proposes to develop counseling and early intervention services that are delivered at school campuses in collaboration with the school districts in Fayette and Lee Counties. We will add four licensed counselors with experience and training in short term solution focused counseling. The school staff has requested these services in order to increase access for all children and specialty services for those with more intense needs. BTCS and community stakeholders including school representatives are members of the Mental Health Task Forces for Fayette and Lee Counties. These school representatives and the other Task Force members identified the issue that schools are experiencing a higher demand for counseling in schools than they have capacity to address. The problem in these Counties is that there are more counseling needs than resources and that the acuity of the needs is frequently beyond the experience and capabilities of most of the school counselors.

Project Goals

The goals over the next five years for BTCS, as the performing provider, are: to establish the service and achieve acceptance and integration of the counseling staff into the school milieu; to improve the appropriateness of referrals from school staff; and to use the relationship between school counselors and BTCS counselors to improve the timeliness and utilization of the services. The goals for youth and families are: to have access to short term solution focused therapy and early intervention; for youth and families to feel a level of satisfaction that will foster utilization of the service; to improve success at school and home; to resolve issues through counseling and intervention and avoid referral to and placement with Juvenile Probation. It is our goal to use this new service access to improve the success of reintegration if referral to Juvenile Probation does occur. We expect to reduce the number of youth who are referred for out of home placement or for crisis intervention services.

Challenges or Issues Faced by the Performing Provider

One challenge in working with schools is that they are governed by Independent School District Boards that must carefully consider any on campus activities related to health and safety. A second challenge we will face is the stigma associated with behavioral health services and the problem that on-site services can inadvertently lead peers to form a negative view of youth accessing these services. A third challenge is that according to the RHP 7 Community Needs Assessment, there are no youth counseling providers in these two Counties.

How the Project Addresses those Challenges

The excellent working relationship that BTCS enjoys currently with the Independent School Districts in Fayette and Lee Counties has built a level of trust that we feel makes it easier to solidify our current understanding with the school districts and get formal agreements to provide services on campus. We will begin seeking these formal agreements prior to approval of this project. Concerning stigma, it is an advantage that BTCS has already established a presence on these campuses and is a known element. We plan to work closely with school administrators to communicate these services as extensions of wellness and good health rather than as interventions for disease. BTCS has a wellness focus in all services and emphasizes the strengths of youth and families, as an evidenced based practice for child serving agencies nationwide. Our counselors will make general presentations and participate in wellness events in the school so that their role can be identified with helping rather than only with intervening with troubled youth. Finally, the workforce in region 7 and especially in these rural counties is thin with respect to well qualified child and family therapists. BTCS has been the LMHA there for over fifteen years and prior to that many of the staff served as part of the State Operated Community Services in the same counties. As a result we are well known and respected in the geographic area and feel we will be able to attract qualified therapists. We are willing to pay a premium rate and to supplement travel expense if need be. More importantly, we feel that we can offer an opportunity for professionals to join a good organization and to have an impact on the lives of children and families in the area. We have well-developed recruitment and retention strategies and resources developed over the last fifteen years and will use them to fill these positions.

How the Project is Related to RHP Goals

The Vision for Region 7 is "Good health is achievable for all people in the region." We feel the project aligns with that vision by creating access in these rural communities in settings that they support: public schools. The project advances RHP Goal 2: "Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting." Youth will be able to access counseling services in the schools they attend every week. Families can take advantage of consultation with licensed professionals and skills training provided in their home communities. The project also advances RHP Goal 6: "Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery." Based on reports of our BTCS crisis workers in these Counties, currently, families transport their child to an Emergency Department in their own community or in Austin because there are no routine services that might prevent worsening problems. Counseling and early intervention should reduce the need for crisis response services and concern for the safety and security of their child and family.

Starting Point/Baseline

Baseline Data

Currently no Youth Counseling program exists in the school districts in Fayette and Lee Counties; therefore, the baseline is 0 in DY 2. We do not have data related to the efficacy of less intense school

services, nor to out of home placements through Juvenile Probation. We will undertake to identify resources and methods to capture and share information across these various child serving agencies.

Time Period for Baseline

The information collected to identify the Baseline will be from DY 3.

Rationale

Reason for Selection of Project Options and Components

We selected Option 1.12.2 because our goal is to improve access to meet the needs of youth and families despite the rural nature and the limited resources of these Counties. According to reports of the Community Resource Coordinating Group, (CRCG, the local multi-agency staffing and planning group) there are insufficient local Counselors to provide care. This project addresses community needs addressed in the RHP 7 Community Needs Assessment, including rural access impeded by lack of transportation, poverty in the region and serious provider shortages. 11% of the population in both Fayette and Lee Counties are below 100% of poverty. 34% of the population in Fayette and 29% in Lee County are below 200% of poverty (see Region 7 Community Needs Assessment.) BTCS served 1,292 youth in FY 2012 most of whom had diagnoses that put them into the range of SED and who were at or below the poverty level with multiple functional deficits to overcome. BTCS provides office based counseling services now for youth through contract with private therapists who travel from Austin and Bastrop. Travel and expense makes these services very limited. We currently provide skills training and some case management in schools but do not provide counseling there. The total number served in FY 2012 in Fayette and Lee Counties was 106 youth. Based on the need identified by the Task Force and the CRCG, we believe the small number of youth accessing services is directly related to lack of availability of those services. Establishing this new school based service should begin to resolve that issue.

Additionally there are no resources for early intervention. It is well known that poverty is one social determinant in the need for behavioral health services and that early intervention reduces its impact. It is the experience of the treatment professionals in these Counties and of the school staff that children who cannot access early intervention with respect to issues will eventually experience more serious issues, resulting in school and social functioning problems. Many times youth express their need for help by acting out at school, self-abuse, and suicidal threats and gestures. Youth experiencing this level of dysfunction are generally referred to or taken to an ED or law enforcement is called and the child is taken to detention or to emergency medical care of some sort. These options are the only one's parents feel they have because they are unable to control the situation and they fear for the safety and health of their child. Additionally, when a school is faced with a child who has serious emotional disturbances and is acting out in the classroom and campus, a large part of the time is spent by teachers and especially by counselors trying to intervene and manage the situation. This time demand prevents them from intervening early to provide counseling to those for who would be prevented from further escalation if there was access to basic counseling as generally provided in schools. High demand children make it difficult to provide early intervention which then leads to more high demand children.

We realize that there are no core project components associated with Option 1.12.2, however we will implement our project consistent with those components listed in 1.12.1 but modified, as follows:

a) Evaluate existing school based counseling services and ensure that specialized short term solution focused therapy is made available to high intensity need youth. Assess identification and referral of high intensity need youth in relation to care access, develop and implement improvements as part of larger project.

b) Review the intervention impact on access to behavioral health services and identify "lessons learned," opportunities to scale campus based counseling services to other school districts and other counties, and identify key challenges associated with expansion of the intervention

.

Reason for Selection of Milestones & Metrics

The milestones and metrics stated in the attached Table reflect the developmental nature of this project for DY2 and DY3. The service does not exist currently; therefore we will measure progress toward development of infrastructure such as policies, training materials, contracts and staff in DY2. The milestones and metrics for DY3 were selected to measure the actual establishment of the service following development of infrastructure and establishment of a process to continuously improve and adjust the service in the interest of the youth, families and schools. The Milestone and Metrics for DY's 4 and 5 were selected to measure quantifiable patient impact, i.e., number of patients in the target population served at these new school sites. Improved access for high intensity need youth is the goal of the project and this Improvement Measure is specifically targeted to that goal and that population.

Unique Community Need Identification Number

CN.4 – Inadequate access to behavioral health care; CN.5 - rural transportation issues; and CN.16 – Lack of services for children

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

BTCS currently has few system reform projects related to children. We are making changes to the Early Childhood Intervention program and offer innovative Autism services both of which will be supported by the learning environment created by adding Therapeutic Foster Care. We actively use peer supports for our adult behavioral health services and use Family Partners to enhance services to youth. These wellness and recovery reform initiatives will be enhanced by introduction of early intervention in schools.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

BTCS provides some outpatient mental health services with funding from the Community Mental Health (CMH) services block grant provided through the Department of State Health Services from US Department of Health and Human Services. **No Federal Funds other than those received through the DSRIP project, including the CMH Block Grant referenced above, will be used to provide these school based services.** This project does not pay for or duplicate services that children and adolescents will receive from clinics. We expect that some youth who are provided counseling in schools will be referred to clinic based services to receive treatment services there including but not limited to medication management, symptom relief and intensive case management.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-6 Patient Satisfaction

IT- 6.1 Percent improvement over baseline of patient satisfaction scores

The full Child CG-CAHPS will be used to measure overall improvement in satisfaction.

Reasons/Rationale for Selecting the Outcome Measure(s)

The Outcome Measure was selected because satisfaction with the experience of care will play a large part in the overall acceptance of this service and behavioral health care in general within the community. If satisfaction is high we can be assured that two of CMS's triple aims, improved access and improved quality, are being achieved. Patient experience is one of the best gauges of health care system improvement. We will select a valid child and family satisfaction instrument that measures the areas above.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects
BTCS is also proposing to provide Child Crisis Respite through Therapeutic Foster Care (RHP Project ID Number: *126844305.1.2*) which supports and enhances Youth Counseling by providing safe, local options to assist in resolution of any crisis events. Frequently youth are in short term crises that can disrupt education and family life if the only resolution to the crisis is removal and placement in a remote institutional setting such as a hospital or secure residential facility. Such a step disrupts the counseling process. Having a short term local option will allow more youth to stay in counseling through completion.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*
126844305.1.2- Child Crisis Respite through Therapeutic Foster Care
List of Related Category 4 Projects *(RHP Project ID Number)*
N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects
186599001.1.1: School Campus Counseling

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
BTCS will participate in all learning collaboratives organized or sponsored by Central Health that are relevant to our projects. We believe it is important to improve and adjust the care provided. We will also participate with ATCIC and we have participated in learning collaboratives through the Texas Council of Community Centers related to Recovery and will continue to look for these opportunities. This exchange of ideas is important and helps us adjust and refine our programs and approaches to care.

Project Valuation

Approach for Valuing Project
This project will seek to serve 75 youth in DY 4 and 100 youth in DY5. These are very high intensity youth who are at risk to be removed from home and placed in a psychiatric hospital or residential treatment facility. Both of these options are expensive and separate the family from the treatment process and seriously reducing the chances for reunification with the family. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs

averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to crisis services provided in this non-traditional way. We are able to compare value of service for Therapeutic Foster Care against traditional institutional care. Reunification and family preservation are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these disparate factors.

126844305.1.1	***1.12.2***	***N/A***	***EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS: YOUTH COUNSELING FOR FAYETTE AND LEE COUNTIE***	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services				*126844305*
Related Category 3 Outcome Measure(s):	*3 IT 6.1*	*126844305.3.1*	*Patient Satisfaction* *Percent improvement over baseline of patient satisfaction scores*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop administrative protocols and clinical guidelines for youth counseling in schools. Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines. Goal: Produce all items above and produce a comprehensive report documenting the development of all items above. Data Source: Administrative protocols; Clinical guidelines Milestone 1 Estimated Incentive Payment *(maximum amount): $192,786* **Milestone 2** [P-4]: Hire and train staff to operate and manage youth counseling in schools Metric 1 P-4.1 Number of staff secured and trained. Goal: Hire 2 counselors in DY 2. Data Source: Project records; Training curricula	**Milestone 3** [P-6]: Establish behavioral health services in new community-based settings in underserved areas. Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered. Goal: Provide counseling in 2 schools. Data Source: EHR Milestone 3 Estimated Incentive Payment: $195,213 **Milestone 4** [P-7]: Evaluate and continuously improve services. Metric 1 [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Establish a PDSA cycle for counseling operations and engage all school districts, participating and planned to participate, in improvement process. Data Source: Project reports including		**Milestone 5** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patients in target population served at these new school sites. **Baseline/Goal:** Baseline – 0, since no such sites are now located in these counties; Goal - serve a total of 75 in DY4. **Data Source: EHR** Data Source: EHR Milestone 5 Estimated Incentive Payment: $433,648	**Milestone 6** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patients in target population served at these new school sites. **Baseline/Goal:** Baseline – 0, since no such sites are now located in these counties; Goal - serve a total of 100 in DY5. Data Source: EHR Milestone 6 Estimated Incentive Payment: $424,012

126844305.1.1	***1.12.2***	***N/A***	***EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS: YOUTH COUNSELING FOR FAYETTE AND LEE COUNTIE***	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services				*126844305*
Related Category 3 Outcome Measure(s):	*3 IT 6.1*	*126844305.3.1*	*Patient Satisfaction* *Percent improvement over baseline of patient satisfaction scores*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment: $192,787	examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 4 Estimated Incentive Payment: $195,214			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 385,573	Year 3 Estimated Milestone Bundle Amount: $390,427		Year 4 Estimated Milestone Bundle Amount: $433,648	Year 5 Estimated Milestone Bundle Amount: $424,012
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,633,660				

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Child Crisis Respite through Therapeutic Foster Care
Project Identifier: 126844305.1.2 Pass 1

Provider: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7. We contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Serious Emotional Disturbance. BTCS is the only provider of public behavioral health services in the four mostly rural Counties representing a population of 153,403.

Intervention(s): BTCS will implement Therapeutic Foster Care (TFC) by recruiting foster parents and certifying homes; developing the protocols, training curriculum and clinical supports necessary to use the homes for crisis respite for youth. BTCS expects to divert youth from admission to a psychiatric hospital or juvenile justice facility. Our TFC Child Respite project will foster children in need of intensive short-term behavioral health services, but not in need of protection. Children receiving or eligible for Department of Family and Protective Services (DFPS) Foster Care are not in the target population for this project and, therefore, DFPS funding is not available for use for this project. No funding is available for children who are not in the CPS system but in need of crisis respite due to behavioral health crisis. **Because this is a different population, no Federal Funding for Foster Care is used in this project.**

Need for the project: Currently youth in crisis may be removed from their families and transported out of their home counties to residential treatment facilities or psychiatric hospitals. This prevents rapid stabilization and participation by families and is therefore a barrier to family preservation. This addresses RHP 7 Community Needs Assessment needs: CN.4 – Inadequate access to behavioral health care; CN.5 - Transportation access for people in the rural areas; CN.6 - Inadequate services throughout the continuum of care for individuals with behavioral health issues, specifically crisis stabilization services; and CN.16 – Lack of services for children.

Target population: The target population is children and adolescents experiencing behavioral health crises and at risk of removal from the home. Because the services are offered locally, we will also provide services to families in order to support reintegration and family reunification. We will serve about 15 youth annually as the program matures. BTCS served 1,292 youth in its 8 County region in FY 2012, 76% of the youth were eligible for CHIP or Medicaid. We expect over 80% of those benefitting from these services will be uninsured or enrolled in CHIP or Medicaid.

Category 1 or 2 expected patient benefits: The project seeks to achieve the utilization of appropriate crisis alternatives.) The metric will be target population reached; number served in this community based crisis alternative. Measurement of the Metric is a count of those receiving crisis services in this location. Currently the only alternatives are out of County and result in extended stays and separation from families. Appropriate alternatives should be local and allow for family participation in therapy services and treatment planning. We expect to serve about 12 youth in DY 4 and 15 in DY 5. The benefit to youth is being able to stay in their natural families.

Category 3 outcomes: IT- 9.1 Our goal is to decrease mental health admissions and readmissions to criminal justice settings; specifically to juvenile probation residential facilities and detention facilities. We expect to achieve a percentage reduction TBD based on baseline to be established in DY 3.

Title of Project: **Development of behavioral health crisis stabilization services as alternatives to Hospitalization: Child Crisis Respite through Therapeutic Foster Care**

Category / Project Area / Project Option: **1.13.1**

RHP Project Identification Number: **126844305.1.2 Pass 1**

Performing Provider Name: **Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services**

Performing Provider TPI: **126844305**

Project Description

Overall Project Description

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7. As the LMHA, we contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Serious Emotional Disturbance ('SED'), that DSHS identifies as a "priority population" for LMHAs. The Federal Definition for youth diagnosed with SED can be found at: http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc . Youth diagnosed with SED are generally having adjustment or functioning difficulties in more than one life domain and therefore experience crisis episodes that disrupt schools and families alike. BTCS proposes to develop a specialized Therapeutic Foster Care (TFC, also called 'Treatment Foster Care') project that will be used to intervene with youth in crisis and divert them from admission to a psychiatric hospital or juvenile justice facility. Specifically, the foster homes in this project will be used to provide safe environments to begin reintegration and family reunification following discharge from hospital or residential facility, thereby shortening lengths of stay; or intervening at the point of crisis and thereby diverting the youth from those facilities with higher levels of care. TFC is a distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In TFC, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. TFC programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings. BTCS is a member of the Mental Health Task Forces for Bastrop, Caldwell, Fayette and Lee Counties and these groups have identified a need for crisis services for youth from this area. Currently there are no behavioral health crisis options available in these Counties.

Project Goals

Over the next five years the outcome goals for the Performing Provider are: to implement Therapeutic Foster Care by recruiting foster parents and certifying homes; and to develop the protocols, training curriculum and clinical supports necessary to use the homes for crisis respite for youth. The goals for youth and families are: to successfully reintegrate children with emotional and/or behavioral needs into their communities and their families—families who are trained to have the skills to meet those needs; for youth experiencing a crisis to be safe and secure; for youth to be maintained and have emotional and/or behavioral needs met in a family setting in the community. The outcomes include safely reducing the number of children in out-of-home care and expediting permanency for children currently in out-of-home placements.

Challenges or Issues Faced by the Performing Provider

A major challenge for this program will involve the regulation and infrastructure needed to operate Foster Care services and to develop the philosophy of care to carry it out. Another major challenge is the identification of suitable homes or facilities, suitable candidates for foster parents and enhanced clinical expertise at the local clinic to carry out needed supports. The Community Needs Assessment for RHP 7 identifies serious provider shortages in the rural counties (see Healthcare Workforce graph, page 5), and identifies lack of crisis stabilization services (see page 7).

How the Project Addresses those Challenges

We are certain we can address the challenge related to regulation and infrastructure because BTCS has reached agreement to collaborate with the Center for Health Care Services (CHCS), the LMHA for Bexar County, which is also a licensed Child Placing Agency, and has been developing foster homes for several years. We will address the philosophy of care challenge by using resources related to the variety of evidenced based practices (EBP) that have been implemented in Therapeutic Foster Care settings, as noted in "Evidenced Based Practices in Treatment Foster Care- A Resource Guide" produced by the Foster Family Based Treatment Association (at http://www.ffta.org/). To address the home and facility issues, BTCS has identified a site in Fayette County which is proximate to the other four RHP 7 counties we serve. Using the excellent reputation of BTCS and the expertise of CHCS we will initiate a strategy to provide enhanced community education and communication to recruit families and additional homes. We will also access resources through the various Foster Care trade associations. This is a standard recruitment strategy. We will provide specialized clinical training for foster parents as specified in the licensure standards and will add licensed and certified clinical staff at the local BTCS clinics in order to provide professional support. Concerning provider shortages, we will use the innovative nature of this program as an inducement to recruit providers. We are confident that qualified professionals will want to participate in such a project.

How the Project is Related to RHP Goals

This project advances RHP Goal 2: "Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting." Currently, families transport their child to an Emergency Department in their own community or in Austin because of concern for the safety and security of their child and family. BTCS clinical staff has experience which demonstrates that short stays away from home and a chance to cool down reduces the need for inpatient admission. The project also advances RHP Goal 6: "Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery." Youth will be able to access crisis respite services and work with their families close to home and in a family environment helping both youth and family.

Starting Point/Baseline

Baseline Data

Currently no Crisis Respite program exists in any of the four Counties BTCS serves in RHP 7; therefore, the baseline is 0 in DY 2. We have some data related to the number of youth hospitalized in State Hospitals, but do not have comprehensive data on ED episodes, private hospital admissions and residential referrals from schools and juvenile probation departments. We will undertake to identify resources and methods to capture and share information across these various child serving agencies.

Time Period for Baseline

The information collected to identify the Baseline will be from DY2.

Rationale

Reason for Selection of Project Options and Components

We selected Project Option 1.13.1 and core components a) – e) in order to address the need for crisis services that will allow youth to stay in the community and reunify with their natural families. Crisis Respite through Therapeutic foster Care expands the options for caregivers and agencies involved with these children and adolescents rather than to assess and transport to Austin or even farther outside of RHP 7 for admission to a hospital or secure residential facility for stabilization. Aside from the distant locations of these stabilization options, we believe this is the best approach, an innovative use of a family oriented community setting rather than a more restrictive community institutional setting. BTCS served 1,292 youth in FY 2012 most of whom had diagnoses that put them into the range of SED and who were at or below the poverty level with multiple functional deficits to overcome. Our number of youth served in Bastrop, Caldwell, Fayette and Lee Counties was 276 for calendar year 2011. Supporting effective growth and relationships of the child through an intensive support and treatment program, this program is designed to assist children transitioning to a less restrictive environment—and, ultimately, into a healthy family situation. This project addresses community needs addressed in the RHP 7 Community Needs Assessment, including rural access This project implements a crisis response for youth that addresses these identified gaps in the continuum of care

This is a very innovative use of Therapeutic Foster Care and we will carry out each of the core components to assure successful implementation. We plan to : **a)** convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services, the numbers of people removed by Juvenile Probation, taken to ED's and admitted to private facilities; **b)** work with community stakeholders and child serving agencies to identify tools to analyze the capacity for service, current utilization patterns and key characteristics of the people to be served; **c)** use local BTCS staff to assess current needs of those who are now and have been detained in the last year; **d)** use the information from stakeholders, from capacity and utilization tools and from assessment of those detained to assess the intervention we are planning to provide against other models as to acceptability and feasibility; and **e)** review the intervention to identify lessons learned and adjust the model with respect to area, intensity and population. There is guidance available, and we plan to take care that the evidenced based practice approach will evolve from a thorough needs assessment process that considers how well it fits with the youth, the staff and the organization. Based on information, BTCS will determine how to implement and to improve. The next step will be to identify and address organizational and community factors that may impede or promote the implementation of the EBP. We view as a positive factor that the culture of BTCS has historically been open to innovative program development and it is part of the tradition of the organization. Once organizational barriers to implementing the EBP have been identified, they should be addressed through formal and informal communication with staff. After this process has successfully proceeded, BTCS will explore how well the programmatic needs match up with a particular EBP. If a good fit is identified, BTCS will begin establishing the necessary elements, including funding, staffing, locations, new materials and technology and new procedures. The next step will be to adjust the curriculum of CHCS to develop an effective training component of the program targeted to this population.

Reason for Selection of Milestones & Metrics

The milestones and metrics stated in the attached Table were selected because of the innovative and developmental nature of this project. The service does not exist currently; therefore we will measure progress toward development of infrastructure such as policies, training materials, contracts and staff in DY2. TFC is an innovative community alternative to institutional care but it will require careful design and ongoing evaluation. We selected appropriate design and evaluation Milestones and Metrics in DY3. The

Milestone and Metrics for DY's 4 and 5 were selected because our goal is to promote utilization of this community based crisis alternative for these high intensity and high need youth. These Milestones and Metrics are specifically related to the targeted population of youth who have experienced separation from their families and removal from the home or are facing separation due to a crisis event. We expect to serve about 12 youth in DY 4 and 15 in DY 5. The benefit to youth is being able to stay in their natural families.

Unique Community Need Identification Number

CN.5 - rural transportation issues; CN.6 – crisis stabilization services; and CN.16 – Lack of services for children

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

BTCS currently has few system reform projects related to children. We are making changes to the Early Childhood Intervention program and offer innovative Autism services both of which will be supported by the learning environment created by adding Therapeutic Foster Care.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

BTCS provides some outpatient mental health services with funding from the Community Mental Health services block grant provided through the Department of State Health Services from US Department of Health and Human Services. This project does not pay for or duplicate services that children and adolescents will receive from clinics but supplements successful use of those services with a healthy nurturing environment. BTCS receives no Federal Funds for foster care services. Those funds are for children in the Child Protective Services (CPS) and we will be providing care for a different group of children who are in psychiatric crisis. **No CPS funds will be used for this population in this project**. The Therapeutic Foster Care participant access to the outpatient services is critical to supplement the project and includes medication management, symptom relief and intensive case management.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-9 Right Care, Right Setting:

IT- 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.

Reasons/Rationale for Selecting the Outcome Measure(s)

Achieving the goal to establish a crisis stabilization alternative in the community will reduce the number of youth who are removed at the point of crisis due to having no other options. Although the Improvement Target references criminal justice it is understood that most youth are not admitted to criminal justice settings but to the various levels of the juvenile justice system to include residential treatment in a secure facility. Youth in crisis cause damage and are disruptive; frequently they are referred to juvenile justice for safety even though the problem is a mental health problem. Crisis stabilization available in the community will reduce those referrals and achieve this outcome.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

BTCS is also proposing to provide youth counseling services in schools in Fayette and Lee Counties. Counseling will be available for youth after they are discharged from crisis respite. Alternatively, if youth who are enrolled in counseling have a crisis episode, they can be stabilized quickly and continue their counseling treatment. They should also create an environment of learning related to expanded behavioral

health services for youth. We also anticipate that some high functioning individuals with Intellectual and Developmental Disabilities, especially youth with Autism, might require and access crisis respite services. Our IDD Assertive Community Treatment project is proposed in Pass 2.

List of Related Category 1 & 2 Projects *(in the order referred to above):*

1268443-05.1.1: Youth Counseling in Schools for Fayette & Lee Counties;

11268443-05.2.2: IDD ACT Project (Pass 2)

List of Related Category 4 Projects *(RHP Project ID Number)*

N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

133542405.2.3: Crisis Residential Program,

186599001.1.1: School Campus Counseling

133340307.2.6: Children's Mental Health Crisis Center

126844305.2.3: Services for Justice-Involved Youth and Adults

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

BTCS will participate in all learning collaboratives organized or sponsored by Central Health that are relevant to our projects. We believe it is important to improve and adjust the care provided. We will also participate with ATCIC and we have participated in learning collaboratives through the Texas Council of Community Centers related to Recovery and will continue to look for these opportunities. This exchange of ideas is important and helps us adjust and refine our programs and approaches to care.

Project Valuation

Approach for Valuing Project

We expect to serve about 12 youth in DY 4 and 15 in DY 5. The benefit to youth is being able to stay in their natural families. These are very high intensity youth who otherwise would be removed from home and placed in a psychiatric hospital or residential treatment facility. Both of these options are expensive and separate the family from the treatment process and seriously reducing the chances for reunification with the family. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to crisis services provided in this non-traditional way. We are able to compare value of service for Therapeutic Foster Care against traditional institutional care. Reunification and family preservation are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these disparate factors.

126844305.1.2	*1.13.1*	*1.13.1 (A-E)*	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION: CHILD CRISIS RESPITE THROUGH THERAPEUTIC FOSTER CARE*** ***CHILD CRISIS RESPITE THROUGH THERAPEUTIC FOSTER CARE***
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 3 Outcome Measure(s):	*3 IT 9.1*	*126844305.3.2*	*Right Care, Right Setting: Decrease in mental health admissions and readmissions to criminal justice settings such as jails and prisons*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers . Metric 1 P-1.1: Metric: Number of meetings and participants. Goal: Hold meetings that are attended by a representative of all of the key groups identified above. Data Source: Attendance lists Milestone 1 Estimated Incentive Payment *(maximum amount): $333,560* **Milestone 2** [P-3]: Develop implementation plans for needed crisis services. Metric 1 P-3.1 Produce data-driven written action plan for development of Crisis Respite through TFC based on gap analysis and assessment of needs. Goal: Document a plan that includes all of the elements above and is specific to	**Milestone 3** [P-4]: Hire and train staff to implement Crisis Respite through TFC. Metric 1 P-4.1: Number of staff hired and trained. Goal: Hire 1 licensed staff and recruit and certify 1 foster parent, certify 1 foster home. Data Source: Staff rosters and training records and training curricula, DFPS licensure reports Milestone 3 Estimated Incentive Payment: $852,840	Milestone 4 [I-X] Increase the utilization of appropriate crisis alternatives. Metric 1 [I-X.1] Target population reached; number served in this community based crisis alternative. Measurement of the Metric is a count of those receiving crisis services in this location. Baseline/Goal: There were no crisis alternatives for youth in these Counties in DY 2 therefore the baseline is 0 for persons served./ Our Goal is to serve 12 youth DY4. Data source: Claims, encounter, and clinical record data. Milestone 4 Estimated Incentive Payment: $870,684	Milestone 5 [I-X] Increase the utilization of appropriate crisis alternatives. Metric 1 [I-X.1] Target population reached; number served in this community based crisis alternative. Measurement of the Metric is a count of those receiving crisis services in this location. Baseline/Goal: There were no crisis alternatives for youth in these Counties in DY 2 therefore the baseline is 0 for persons served./ Our Goal is to serve 15 youth DY4. Data source: Claims, encounter, and clinical record data. Milestone 5 Estimated Incentive Payment: $883,802

126844305.1.2	***1.13.1***	***1.13.1 (A-E)***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION: CHILD CRISIS RESPITE THROUGH THERAPEUTIC FOSTER CARE CHILD CRISIS RESPITE THROUGH THERAPEUTIC FOSTER CARE***
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 3 Outcome Measure(s):	*3 IT 9.1*	*126844305.3.2*	*Right Care, Right Setting: Decrease in mental health admissions and readmissions to criminal justice settings such as jails and 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)**
implementation of TFC. Data Source: Written plan Milestone 2 Estimated Incentive Payment: $333,561			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $667,121	Year 3 Estimated Milestone Bundle Amount: $852,840	Year 4 Estimated Milestone Bundle Amount: $870,684	Year 5 Estimated Milestone Bundle Amount: $883,802
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,274,447			

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Outpatient Substance Addiction Services for Adult and Youth in Bastrop, Caldwell, Fayette and Lee Counties
126844305.1.3 Pass 2

Provider: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7 and for four other Counties in nearby RHPs. We are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. We are the only provider of public behavioral health services in these four mostly rural Counties with a population of 153,403.

Intervention(s): BTCS proposes to establish and operate outpatient substance abuse treatment sites in all four of those Counties to meet the needs of a growing rural and suburban population, especially the poor, uninsured and/or underinsured. The services will be located in our current facility in Bastrop County and we plan to rent space in Fayette and Lee Counties. The facility in Bastrop County is used for outpatient services and will need no renovation or capital investment to make it ready for services. We plan to locate the service in Caldwell County in the facility that will be used for the Integrated Primary Healthcare and Behavioral Healthcare in Lockhart. We will provide supportive outpatient and intensive outpatient treatment.

Need for the project: There are no licensed intensive outpatient and supportive counseling substance abuse programs in any of these Counties. To receive services people must travel into Travis County. For those who are poor and uninsured, the problem is exacerbated because there is no public transportation and even if transportation can be acquired and paid for, substance abuse treatment is limited and frequently unavailable throughout the Region. This addresses RHP 7 Community Needs Assessment needs: CN.4 – Inadequate access to behavioral health care; CN.5 - Rural transportation issues; and CN.16 – Lack of services for children.

Target population: Target population is community referrals, and those referred from ED's in need of outpatient substance abuse services. BTCS served over 7,769 with behavioral health disorders in FY 2012. An average of 43% of adults were eligible for Medicaid; 76% of youth were eligible for CHIP or Medicaid and 73% of BTCS clients are below the federal poverty level. Approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 250 people a year per site within five years.

Category 1 or 2 expected patient benefits: The project reduces inappropriate use of ED by this population which improves their lives through stable services in a medical home; and improves community health by opening access for those who truly need ED. The project seeks to provide services to 750 people in DY4 and 1,000 in DY5 in the four Counties. The Improvement Milestone is I-X The number of people accessing this new service and Metric is the Target Population reached.

Category 3 outcomes: IT-3.8 Our goal is to reduce the behavioral health /substance abuse 30 day readmission rate to detoxification and residential facilities by a percentage rate TBD after the baseline is established in DY 3.

Identifying Project and Provider Information

Title of Project: **Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Outpatient Substance Addiction Services for Adult and Youth in Bastrop, Caldwell, Fayette and Lee Counties**

Category / Project Area / Project Option: **1.12.2**

RHP Project Identification Number: **126844305.1.3 Pass 2**

Performing Provider Name: **Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services**

Performing Provider TPI: **126844305**

Project Description

Overall Project Description

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7 and for four other Counties in nearby RHPs. In that capacity we are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. That responsibility includes identifying gaps in service or barriers to access for persons residing in the area. BTCS proposes to establish and operate outpatient substance abuse treatment sites in all four of those Counties to meet the needs of a growing rural and suburban population, especially the poor, uninsured and/or underinsured. The services will be located in our current facility in Bastrop County and we plan to rent space in Fayette and Lee Counties. We plan to locate the service in Caldwell County in the facility that will be used for the Integrated Primary Healthcare and Behavioral Healthcare in Lockhart. That site is included in the BTCS proposed DSRIP project, 126844305.2.4. Each of the sites will be licensed for both supportive outpatient counseling and intensive outpatient services. The facility in Bastrop County is used for outpatient services and will need no renovation or capital investment to make it ready for services. To accomplish this expansion of services we will recruit and hire licensed counselors and prepare policies procedures and treatment protocols in order to secure Licensure.

Our goal is to improve access to community based outpatient services for those with limited resources. Many of these individuals need outpatient services following a detoxification stay in Travis County or after an ED visit in their home county or Travis County. Access to outpatient treatment following detoxification is essential to recovery. "Admissions to detoxification treatment represent a special category of admissions. They are generally initiated because of an acute need for medical care. Detoxification is ideally followed by a transfer to outpatient or rehabilitation/residential treatment." (Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS): 1997-2007. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-47, DHHS Publication No. (SMA) 09-4379, Rockville, MD, 2009.) The relapse rate for those in treatment for substance use disorder is 40 to 60% and the variation in rate depends largely on the length of time sobriety

is maintained following detoxification. The intensive outpatient substance abuse program and the supportive counseling services are well known in the industry and follow specific licensure and curriculum requirements. Intensive outpatient services will be provided four to six hours a day five days a week in group settings. Supportive outpatient services will be provided in group and individual sessions based on the stage of recovery and needs of the clients. We will provide psycho-education, peer support groups, solution focused and multi-faceted approach to care to include motivational interviewing, co-occurring psychiatric and substance use disorder services. We expect the variety of services available, responsiveness of the design, staffing and locations to improve behavioral health functioning outcomes and significantly improve satisfaction. This project builds on the expertise and resources of BTCS related to services for the individuals with substance use disorders.

Project Goals

The goal of the expansion is to add intensive outpatient and supportive counseling substance abuse services in Bastrop, Caldwell, Fayette and Lee Counties. With this expansion we expect to improve health outcomes for persons in this area who now have limited access to behavioral health services. There are no licensed intensive outpatient and supportive counseling substance abuse programs in any of these Counties. To receive services people must travel into Travis County. For those who are poor and uninsured, the problem is exacerbated because there is no public transportation and even if transportation can be acquired and paid for, substance abuse treatment is limited and frequently unavailable throughout the Region. Our goals include: 1) establish intensive outpatient and supportive outpatient substance abuse services in each of the four Counties; 2) provide behavioral health care that is multi-disciplinary, recovery oriented and comprehensive; and 3) provide behavioral health care, specific to substance use disorders, to all those in need regardless of income, insurance status or diagnosis. We expect that within five years, when these sites are fully operational, each of the locations has the potential to serve 250 persons a year.

Challenges or Issues Faced by the Performing Provider

The primary challenge for this project is for BTCS to gain acceptance from other health care providers, referral sources and the public as a provider of comprehensive substance abuse treatment services and to receive referrals from a broad range of community resources. Currently BTCS is known as the Outreach, Screening, Assessment and Referral (OSAR) entity throughout a 24 county region of central Texas. We provide screening, assessment and referral for state funded substance abuse treatment but we do not directly provide substance abuse treatment services. We are confident in our ability to develop and offer a comprehensive range of services for adults and youth in licensed behavioral facilities that are accessible, responsive and integrated into the community; however these programs will be successful only if referrals are forthcoming.

How the Project Addresses those Challenges

The excellent working relationship that BTCS enjoys currently with schools, law enforcement, elected officials and health care providers in these Counties provides a level of trust that we feel makes it easier to communicate new services and collaborate on processes and referral criteria. We will begin seeking opportunities to provide communication of our plans even before the project begins. As stated below, we will convene community stakeholder groups in DY2 to assess the need and develop operational plans, policies and procedures. Working together will help overcome the challenge. It is also an advantage that BTCS has already established a presence in these communities and is a known element. We will continue to participate in community task forces and forums to promote treatment and recovery and promote the success of treatment to the public.

How the Project is Related to RHP Goals

The Vision for Region 7 is, "Good health is achievable for all people in the region." We feel the project aligns with that vision by creating access in these rural and suburban communities. The project addresses RHP Goal 1. "Prepare and develop infrastructure to improve the health of the current and future Region 7 populations;" Goal 2. "Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting;" and Goal 6. "Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery." A successful program will reduce disparity in treatment for the poor and uninsured/underinsured and lead to a healthier more productive community. Over the next five years we expect the increase in the number of people accessing outpatient substance use disorder treatment to result in an outcome of reduction in the number of readmissions to detoxification facilities and substance abuse related ED visits for the four Counties and for Travis County. The goals stated above related to establishing this new service and educating the community about the need for intervention and treatment will directly affect achievement of the outcomes.

Starting Point/Baseline

Baseline Data

This is a new project for BTCS in the four Counties. There is no program for substance abuse treatment in the Counties now and therefore the baseline for DY 2 is 0.

Time Period for Baseline

The time period of the baseline is DY 2.

Rationale

Reason for Selection of Project Options and Components

We selected Option 1.12.2 because our goal is develop infrastructure by expanding the number of locations where substance abuse services are offered in rural and underserved areas. RHP 7 Community Needs Assessment identifies needs related to rural access impeded by lack of transportation, poverty in the region and serious provider shortages. 11% of the population in both Fayette and Lee Counties are below 100% of poverty. 34% of the population in Fayette and 29% in Lee County are below 200% of poverty, (RHP 7 Community Needs Assessment.) "According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3 percent of persons aged 12 or older); of these, only 2.6 million—11.2 percent of those who needed treatment—received it at a specialty facility."
http://www.drugabuse.gov/publications/drugfacts/treatment-statistics. Any barriers to access can cause the difficult decision to seek treatment to be deferred or the problem denied. As stated above, BTCS does not currently provide behavioral health care to all persons, only to those in the priority population. We also do not provide substance abuse treatment as part of the behavioral health service array. Both of these are identified needs in this area. One critical disparity identified for Region 7 is scarcity of behavioral health services throughout the region and especially in rural areas. "Seton Shoal Creek Hospital (in Travis County) is Region 7's only hospital-based inpatient chemical dependency facility (22 beds)… A recently convened stakeholder group for behavioral health stakeholders from Travis County identified inadequate services throughout the continuum of care for individuals with behavioral health issues. These shortages include…prevention and supported recovery…outpatient treatment and …intensive outpatient…" among other needs. (RHP 7 Community Needs Assessment.)

Project Components:
Although 1.12.2 does not have required core components listed with it, it is in the same Project Area as 1.12.1 and those required core components were used as a guide for our planned approach. We have reviewed the components, modified them and will address them as below:
a) *Evaluate existing locations of behavioral health clinics and to identify barriers to access including, transportation, operating hours, admission criteria and acceptable payment.* We know that our current locations do not offer substance abuse services and that there are none in these counties for the poor and uninsured/underinsured. As we open for services we will use satisfaction surveys and information from patients and families to determine how to eliminate barriers to service access.
b) *Review the interventions impact on access to behavioral health services and identify "lessons learned," 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.* We will establish a Plan, Do, Study, Act (PDSA) cycle improvement process through the Quality Management department of BTCS to collect and analyze data related to these interventions. That data will include ECHO™ Satisfaction Survey results and Electronic Health Record (EHR) data related to functioning scales and frequency in the use of higher levels of care such as Emergency Departments (EDs) and inpatient psychiatric care. We will assess the results, make improvements operations. We will hold community planning meetings with providers, patient advocates and community leaders to assess expansion opportunities.

Reason for Selection of Milestones & Metrics
We chose Milestones and Metrics for DY 2 and 3 that represent the developmental nature of this new service. We will measure and report the development of policies and procedures, hiring staff and establishing the service. We know that achieving referrals and local access are important to be able to serve the target population, so we selected the people served in this new service as the Improvement Measure. The baseline in DY 2 is 0 we will serve 750 people in DY 4 and 1,000 in DY 5..
Unique Community Need Identification Number
CN.4 – Inadequate access to behavioral health care; CN.5 - Rural transportation issues; and CN.16 – Lack of services for children
How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative
Currently BTCS provides behavioral health care only to adults with serious mental illnesses and or youth with severe emotional disturbances. BTCS is also the OSAR for these four Counties and twenty others, as described in the "Challenge" section above, but provides no direct substance abuse treatment services. As indicated there are no licensed substance abuse programs in the Counties. This project would continue the current direction of BTCS and provide integrated care; and to improve access in rural areas, for low income individuals and for everyone who requests and needs services.
Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
BTCS receives funds from U.S. Department of Health and Human Services (DHHS) including Substance Abuse Prevention and Treatment Block Grant used to operate OSAR services in all four counties; and Community Mental Health services block grant used for outpatient mental health services. These DHHS funds will not be used for direct services in this project; however, participants could be referred and treated in those other programs ongoing or upon discharge. This project enhances and extends those services in the community; therefore, this is complementary to the DHHS funded activities.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Reasons/Rationale for Selecting the Outcome Measure(s)

This is a stand-alone measure. We selected this measure because the goal of this project is to help people who have been in some inpatient or other detoxification program to transition to stable living in the community by providing access to community outpatient services. The cycle of relapse and return to hospital or residential detoxification services is a major disruption for individuals seeking to achieve recovery. It is also costly to the health care system and devastating to individuals and families. We believe that measuring the reduction in re-hospitalization will be a good indicator of success for the program and a good indicator of success on a personal basis for those enrolled in the program. Low income individuals cannot now access outpatient care and are left in this cycle of relapse. Extended sobriety and productivity will improve their health outcomes.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

BTCS has also proposed a Youth Counseling project and Transitional Housing project. Both are supported by increased access to local substance abuse counseling and intensive outpatient. We also proposed case management and court liaison Services to Justice Involved Adults and Youth and local treatment options will support that project. Finally, as above, we plan to co-locate this service in Caldwell County in the Primary Care / Behavioral Care Integration site we have proposed.

List of Related Category 1 & 2 Projects *(in the order referred to above):* 1268443-05.*1.1;* 1268443-05.2.*1;* 1268443-05.2.*3; and* 1268443-05.2.4

List of Related Category 4 Projects *(RHP Project ID Number)*

N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

133340307.2.3: Co-occurring Psychiatric and Substance Use Disorder
137265806.2.3: Substance Abuse Disorder Navigation
137265806.2.4: Behavioral Health Assessment and Resource Navigation

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

BTCS will participate in all learning collaboratives organized or sponsored by Central Health that are relevant to our projects. We believe it is important to improve and adjust the care provided. We will also participate with ATCIC and reach out to Hill Country MHDD Centers to participate in learning collaboratives with them. This exchange of ideas is important and helps us adjust and refine our programs and approaches to care.

Project Valuation

Approach for Valuing Project

This project seeks to serve 750 adults and youth in DY 4 and 1,000 adults and youth in DY 5. These services are critical to the health and well-being of the community in this underserved area. The valuation

calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to traditional substance abuse outpatient services in relation to psychosocial and case management based mental health services. We should be able to compare value across these very different modalities.

126844305.1.3	***1.12.2***	***N/A***	***EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS: YOUTH COUNSELING FOR FAYETTE AND LEE COUNTIES***	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services				*126844305*
Related Category 3 Outcome Measure(s):	*3 IT 3.8*	*126844305.3.4*	*Behavioral Health /Substance Abuse 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop administrative protocols and clinical guidelines for projects selected. Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Goal: Produce a manual of operations that can be used to establish administrative and clinical practices. *Data Source:* Administrative protocols; Clinical guidelines Milestone 1 Estimated Incentive Payment: $921,756	**Milestone 2**: [P-4]: Hire and train staff to operate and manage projects selected. Metric 1 [P-4.1]: Number of staff secured and trained Goal: Develop curricula and hire licensed staff sufficient to begin providing outpatient services. Data Source: Project records; Training curricula as develop in DY 2 Milestone 2 Estimated Incentive Payment: $499,633 **Milestone 3:** [P-6]: Establish behavioral health services in new community-based settings in underserved areas. Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered Goal: Establish 2 sites Milestone 3 Estimated IncentivePayment: $499,633		**Milestone 4** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patients in target population served at these new sites. **Baseline/Goal:** Baseline – 0, since no such sites are now located in these four Counties in the RHP; Goal - serve a total of 750 in DY4. **Data Source: EHR** Milestone 4 Estimated Incentive Payment: $1,067,335	**Milestone 5** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patients in target population served at these new sites. **Baseline/Goal:** Baseline – 0, since no such sites are now located in these four Counties in the RHP; Goal - serve a total of 1,000 in DY5. **Data Source: EHR** Milestone 5 Estimated Incentive Payment: $1,031,954
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $921,756	Year 3 Estimated Milestone Bundle Amount: $999,266		Year 4 Estimated Milestone Bundle Amount: $1,067,335	Year 5 Estimated Milestone Bundle Amount: $1,031,954
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $4,020,311				

Central Texas Medical Center
Category 1 DSRIP Projects

Performing Provider: Central Texas Medical Center

Project Title: Expanding Primary Care capacity for low-income adult resident of Hays County, TX

Project Identifier: 121789503.1.1 Pass 1

Provider: Central Texas Medical Center is a 178-bed hospital providing a wide range of complex healthcare services in San Marcos, Texas and neighboring communities. The CTMC staff of over 700 employees works with more than 220 active and consulting physicians.

Intervention(s): Central Texas Medical Center will create the Central Texas Healthcare Collaborative Clinic (CTHC), a new primary care clinic that will offer expanded and integrated health care services to low-income adult residents of Hays County. The CTHC clinic will increase services formerly provided by the County by offering additional service hours and access to primary care physicians. This expanded primary care capacity will enable the CTHC clinic to serve more people, and enhance healthcare service delivery through referrals to area specialists, access to prescriptions and outpatient diagnostic services .

Need for the project: Per the RHP needs assessment, Hays County was the fastest growing county in the RHP between 2000 and 2010 growing 61% during the decade. The County is projected to grow an additional 36% to a population of 213,000 by 2016 with large projected growth for residents aged 55 – 64. Despite its recent population growth, Hays County has a limited safety net infrastructure for primary health care services. One-fourth of the County's adult population is uninsured with just under one-third living under 200% of the FPL. These demographic indicators highlight the need for primary care access for low-income adults.

Target population: The target population is low-income adults that do not qualify for Federal or State health assistance programs and cannot access private health care coverage. The clinic will also offer primary care services to Medicaid beneficiaries and those qualifying for participation in the County Indigent Program.

Category 1 or 2 expected patient benefits: By DY5, through expanded hours and staffing, the clinic expects to realize a 56% increase in primary care capacity. In addition to providing increased access for current patients, this additional capacity will enable the clinic to provide primary care services and specialty care access to an additional 300 eligible adults by the end of the waiver program.

Category 3 outcomes: The Category 3 outcome measure will be IT-9.2, ED appropriate utilization. In Hays County, low-income, uninsured adult residents have limited or few options for accessing primary care services. This places a significant burden on hospital emergency departments within the County and the RHP. Emergency departments become the only option for this targeted population to be treated by a physician and/or access care after hours. During DY2 and DY3 baseline ED utilization data will be captured in order to establish specific improvement targets in DY 4 and DY5.

Title of Project: **Expanding Primary Care capacity for low-income adult residents of Hays County, TX**

Category / Project Area / Project Option: **Category 1: Infrastructure Development Intervention 1.1.2: Expanding existing primary care capacity.**

RHP Project Identification Number: **121789503.1.1 Pass 1**

Performing Provider Name: **Central Texas Medical Center**

Performing Provider TPI: **121789503**

Project Description

Overall Project Description: Historically, Hays County has operated a health care clinic in San Marcos, Texas. Through the services of one nurse practitioner, this clinic provided primary care services to all County residents specifically targeting the uninsured and/or underinsured population that has few options, other than area emergency departments, to receive primary care. Based on County demographics, the need for expanded, integrated health care services is far greater than what the County infrastructure could support. As a result, Hays County elected to discontinue operation of this clinic. In order to fill this void, Central Texas Medical Center will create the Central Texas Healthcare Collaborative Clinic (CTHC), a new primary care clinic that will offer expanded and integrated health care services to low-income adult residents of Hays County.

Through this project, the CTHC clinic will increase services formerly provided by the County by offering additional service hours and access to primary care physicians. This expanded primary care capacity will enable the CTHC clinic to serve more people, and enhance healthcare service delivery through referrals to area specialists, access to prescriptions and outpatient diagnostic services .

Three core project components will be initiated to expand primary care capacity and access:

A) Expand primary care clinic space: The CTHC clinic will be located in the former Hays County Clinic. This 9,200 square foot clinic will provide adequate space for this project therefore clinic expansion is not necessary. However, the space will be renovated in order to accommodate more providers, create improved workflows, reduce wait times and increase patient satisfaction.

B) Expand primary care clinic hours: Initially, service hours will replicate what the County has historically offered which is 32 hours per week. Over the course of the project, clinic hours will be expanded from 32 to 44 hours per week to include evening appointment options.

C) Expand primary care clinic staffing: Initially, services will be delivered by a nurse practitioner supervised by a physician in accordance with Texas Medical Board rules. Staffing at the CTHC will be expanded to include at least one primary care physician. Physician(s) will be scheduled on a rotating basis to provide evening and daytime appointment options. A physician will not only expand primary care

access but offer a wider scope of services that will be beneficial when managing patients with urgent care needs and/or complex medical needs.

Project Goals: By DY5, through expanded hours and staffing, the increase to 6,600 annual encounters from the starting point of 4,230 annual encounters will represent a 56% increase in primary care capacity. In addition to providing increased access for current patients, this additional capacity will enable the clinic to provide primary care services and specialty care access to an additional 300 eligible adults by the end of the waiver program.

The creation and expansion of the CTHC clinic will increase access to primary care services, reduce wait times and delayed care, increase patient satisfaction, create timely access for follow-up visits, better manage chronic and/or complex diseases and reduce reliance on emergency departments for primary care. This promotes the right care, at the right time, in the right place.

Challenges or Issues Faced by the Performing Provider/How the Project Addresses those Challenges

As the Needs Assessment notes, Hays County is designated as a Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA), with 1,866 residents per primary care physician which exceeds the Texas ratio of approximately 1,500 residents per primary care physician. As a result, access to primary care physicians is challenging, especially for low-income residents. This is especially important for patients with complex medical needs that would benefit from more coordinated care under the supervision of a physician. Live Oak Health Partners (LOHP), a multi-specialty physician practice in Hays County, employs several primary care physicians (PCP) and recently recruited an additional two PCPs and will recruit at least one additional provider specifically for this Waiver project. It is anticipated that recruiting a provider will be challenging, especially to provide after-hours care. However, recruiting a provider into an existing primary care practice, with appropriate call coverage, makes this opportunity more attractive. It is likely that an income guarantee program will be necessary to draw qualified candidates.

Hays County offers no mass transportation options. Offering evening appointment options will not only enhance access to services but will also provide greater flexibility to better accommodate working adults or those who must rely on a working adult for their transportation needs. Extended hours will also assist individuals that do not have daytime childcare options. Many times, the only "after hours" option is area hospital emergency departments which then become the destination for primary care services.

It may be challenging to reach target populations that would most benefit from CTHC Clinic services. In an effort to "market" these services, area emergency department personnel and hospital-based case managers and social workers will be made aware of this clinic and program. Low-income, uninsured adult Hays County residents frequently accessing an emergency department for non-urgent care, especially when the clinic is open, will be referred to this program. As a component of discharge planning, hospital-based case managers and social workers are in a unique position to identify patients appropriate for coordinated outpatient care for non-complex chronic conditions.

How the Project is Related to RHP Goals: This project aligns with regional goal #2 by reducing health system costs through expanded opportunities for patients to access the most appropriate care in the most appropriate setting. Access to primary care services in a clinic setting, especially during evenings, reduces reliance on high cost emergency department care for non-urgent services and lessens the potential for individuals to forego care or delay care which can lead to avoidable complications. Enhancing a primary care access point supports regional goal #5, prevention education and healthy lifestyles to improve population health. Finally, regional goal #7 is achieved by providing access to primary care physicians can improve the patient experience of care and the quality of care, especially for patients with complex medical needs.

Starting Point/Baseline

Baseline Data: During DY2**,** CTHC will offer approximately 90 appointments per week, approximately 4,230 encounters per year, with no evening appointment options. Services will be rendered by one nurse practitioner only.

By DY5, this project will create access for an additional 2,370 primary care encounters per year. Expanded capacity will increase primary and specialty care access to an additional 300 eligible adults who do not do not qualify for Federal or State health assistance programs and cannot access private health care coverage.

Time Period for Baseline: 2012

Rationale

Reason for Selection of Project Options and Components: Per the RHP needs assessment, Hays County was the fastest growing county in the RHP between 2000 and 2010 growing 61% during the decade. The County is projected to grow an additional 36% to a population of 213,000 by 2016 with large projected growth for residents aged 55 – 64. Despite its recent population growth, Hays County has a limited safety net infrastructure for primary health care services.

One-fourth of the County's adult population is uninsured with just under one-third living under 200% of the FPL. According to the US Census Bureau via the 2011 American Community Survey, 16.6% of Hays County residents between 18 – 64 years of age are under the FPL. San Marcos, one of the largest cities within the county with a population of just under 45,000 has just over 38% of residents living below the Federal Poverty Level. Of this, 41.6% are aged 18 – 64 years. Just over 8,200 San Marcos residents are below 50% of the FPL. These demographic indicators highlight the need for primary care access for low-income adults that do not qualify for Federal or State health assistance programs and cannot access private health care coverage.

There are two Federally Qualified Health Centers (FQHCs) that provide services within the County. These help address some, but not all of the needs. When healthcare is inaccessible, many individuals are forced to forego care, delay care which can lead to avoidable complications, or access care via hospital

emergency departments. Unfunded patients comprise approximately 25% of all emergency department encounters at Central Texas Medical Center.

It is anticipated that the Central Texas Healthcare Collaborative Clinic will increase/improve access, provide better management of chronic and/or complex diseases and be a step in the right direction to break the cycle of high cost emergency room reliance for primary care services. Additionally, this clinic/program will also provide a referral option for emergency department personnel, hospital-based case managers and social workers when they identify patients medically appropriate for clinic services. This will help steer patients to the appropriate, lower-cost setting for their healthcare needs. The metrics/milestones for this project will focus on increased clinic volume throughout the waiver period.

Reason for Selection of Milestones & Metrics In order to expand existing primary care capacity it is necessary to increase hours and enlist additional primary care providers to render care. Increased encounters will demonstrate improved access to primary care and provide primary care access to a population that has few or no options for clinic-based services.

Unique Community Need Identification Number: CN.1, CN.2, CN.8.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative: The creation of the Central Texas Healthcare Collaborative Clinic is a new initiative for Central Texas Medical Center. Through this project the CTHC clinic will expand primary care capacity, formerly provided by the County, by offering additional service hours and access to primary care physicians.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) The Central Texas Health Care Collaborative does not receive funding from HHS.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected: The Category 3 outcome measure will be OD-9: Right Care, Right Setting, IT-9.2: ED appropriate utilization. This is a standalone measure.

Reasons/Rationale for Selecting the Outcome Measure(s): In Hays County, low-income, uninsured adult residents have limited or few options for accessing primary care services. This places a significant burden on hospital emergency departments within the County and the RHP. Emergency departments become the only option for this targeted population to be treated by a physician and/or access care after hours. Patients that are medically screened and treated in an ED setting likely struggle with uncoordinated care and may not have the resources or funding to follow discharge instructions including access to prescriptions and appropriate follow-up/after care.

According to the Texas Medical Association website statistics highlighting the uninsured in Texas, "the uninsured are up to four times less likely to have a regular source of health care and are more likely to die from health-related problems. They are much less likely to receive needed medical care, even for symptoms that can have serious health consequences if not treated. Lacking a medical home, uninsured

people tend to look for health care in the emergency room, the most expensive setting they could possibly choose."

Although historical data are not available for Hays County, per the RHP 7 Community Needs Assessment, a 2011 analysis of emergency department (ED) visits by uninsured and underinsured patients in Travis County found that almost 50% of ED visits were for services that could have been provided in a primary care setting. An additional 6% required emergent care which potentially could have been addressed by appropriate ambulatory care.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects. This is the only DSRIP project submitted by CTMC.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*
N/A

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-1: Potentially Preventable Admissions;
RD-2: 30-Day Readmissions;

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Hill Country MHDD's Hays County Mental Health Center Integrated Care (133340307.2.1) has a similar target population. St. Mark Medical Center's Expanding Access to Specialty Care (176692501.1.1) has a similar intervention. Other related projects include:

133542405.2.5 - Austin Travis County Integral Care - Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults

126844305.2.4 - Bluebonnet Trails Community Services - Design, implement, and evaluate project that provides integrated primary and behavioral health care services: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County

307459301.2.1 - Community Care Collaborative - Patient-Centered Medical Home Project

307459301.1.2 - Community Care Collaborative - Expanded Primary Care Hours at Community-Based Outpatient Settings

307459301.1.3 - Community Care Collaborative - Mobile Primary Care

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health as RHP 7's anchor, will foster the development of topical learning collaborative; e.g. smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach for Valuing Project: Our approach included the size and scope of the plan, overall value and priority of this project within the community, demographics of the target population, waiver goals, financial investment/infrastructure development, staffing, cost avoidance and the identified needs of the target population.

This project addresses a priority community need for improved access to primary care. Establishing a medical home for this at-risk population, reduces health system costs by expanding opportunities for patients to access the most appropriate care in the most appropriate setting. The expected core value of this project is to reduce reliance on high cost emergency department interventions for non-urgent services thus preserving this resource for true crises care. Promoting accessible, coordinated and consistent outpatient health services will lessen the potential for individuals to forego care or delay care which can lead to avoidable complications. A secondary value is better long-term management of chronic and/or complex disease processes that can reduce potentially avoidable hospital admissions and re-admissions. This will be accomplished through clinic referrals to area specialists, access to prescriptions and outpatient diagnostic services.

The population of Hays County is projected to grow an additional 36% by 2016. In addition to the direct benefits for the patients served by the CTHC, this project provides overall value to the entire Hays County community by diverting emergency department visits, increasing access for other residents with true emergencies and potentially limiting the need for additional facilities to support the growing population.

Rationale/Justification for Valuation: The core value of this project is providing care in the right setting at the right time and reduced utilization of higher cost healthcare resources.

121789503.1.1	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP –] 1.1.2*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP] 1.1.2 (A-C)*	*EXPANDING PRIMARY CARE CAPACITY FOR LOW-INCOME ADULT RESIDENTS IN HAYS COUNTY, TX*	
Central Texas Medical Center				*121789503*
Related Category 3 Outcome Measure(s):	*121789503.3.1*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [– P-5]: Hire additional primary care providers and staff. Metric 1 [P-5.1]: Documentation of increased number of providers and staff.] Baseline/Goal: 0 PCPs/at least one PCP hired Data Source: Contract or other documentation Milestone 1 Estimated Incentive Payment $2,894,250	**Milestone 2** [P-4]: Expand the hours of a primary care clinic including evening hours. Metric 1 [P-4.1]: Increased number of hours at a primary care clinic over baseline. Baseline/Goal: 32 hrs/38 hrs Data Source: Clinic Documentation Milestone 2 Estimated Incentive Payment: $1,522,200 **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: 4230 encounters/visits Goal: 5700 encounters/visits Data Source: Clinic Documentation Metric 2 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Baseline: 0 (new program) Goal: 100 Data Source: Clinic Documentation		**Milestone 4** [P-4]: Expand the hours of a primary care clinic including evening hours. Metric 1 [P-4.1]: Increased number of hours at a primary care clinic over baseline. Baseline/Goal: 38 hrs/42 hrs Data Source: Clinic Documentation Milestone 4 Estimated Incentive Payment: $1,565,625 **Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 6300 encounters/visits Data Source: Clinic Documentation Metric 2 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: 200	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 6600 encounters/visits Data Source: Clinic Documentation Metric 2 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: 300 Data Source: Clinic Documentation Milestone 6 Estimated Incentive Payment: $2,607,750

121789503.1.1	***[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP –] 1.1.2***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP] 1.1.2 (A-C)***	***EXPANDING PRIMARY CARE CAPACITY FOR LOW-INCOME ADULT RESIDENTS IN HAYS COUNTY, TX***	
Central Texas Medical Center				*121789503*
Related Category 3 Outcome Measure(s):	*121789503.3.1*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 3 Estimated Incentive Payment: $1,522,200		Data Source: Clinic Documentation Milestone 5 Estimated Incentive Payment: $1,565,625	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,894,250	Year 3 Estimated Milestone Bundle Amount: $3,044,400		Year 4 Estimated Milestone Bundle Amount: $3,131,250	Year 5 Estimated Milestone Bundle Amount: $2,607,750
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $11,677,250				

Community Care Collaborative

Category 1 DSRIP Projects

Community Care Collaborative

The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities

307459301.1.1 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will implement and use chronic disease management registry (DMR) functionalities to alert and inform care teams when patients with two or more chronic diseases require intervention and follow up, according to the CCC's newly formed Chronic Care Management Model (DSRIP Project 307459301.2.2). The DMR functionalities will be one component of an integrated health information technology (HIT) solution for CCC providers that will support analytics, patient care, care management interventions, and disease management. As the HIT captures clinical histories and real values, it will support not only patient management through a medical home but a clinician's next decision at a point of care.

Need for the project: The current system of care has no coordinated Health Information mechanismto track and manage the care that the complexly ill receive. The design of clinically-integrated DMR capabilities across the CCC contracted provider network will help ensure that providers have access to real-time clinical data, reports, reminders, and analytics to better manage care for these patients across the service continuum.

Target population: All care providers within the CCC network will be expected to implement and use the DMR functionalities. Of the 50,000 patients at or below 200% of FPL that the CCC expects to cover initially, an estimated 18,000 have multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes; many more have only one chronic condition. In addition, all patients who come into contact with the CCC, regardless of payor, will benefit from DMR functionality. This includes thousands of low-income uninsured and Medicaid patients.

Category 1 or 2 expected patient benefits: The project will add at least twelve thousand patients to the providers' expanded DMR functionalities by DY5: 3000 in DY2, 4000 in DY4, and 5000 in DY5. These patients will benefit, in turn, from the enhanced care that providers will be able to offer through use of the DMR.

Category 3 outcomes: Three category 3 outcomes were chosen from Outcome Domain 1, Primary Care and Chronic Disease Management:

IT-1.4: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – diuretic

IT-1.12 Diabetes care: Retinal eye exam (NQF 0055)

IT-1.14: Diabetes care: Microalbumin/Nephropathy (NQF 0062)

Project Title: **The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities**

Project Option: **1.3.1 – Implement/enhance and use chronic disease management registry functionalities**

RHP Project Identification Number: **307459301.1.1 Pass 3**

Performing Provider Name: **Community Care Collaborative (CCC)**

TPI: **307459301**

Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this DSRIP project, the CCC is proposing to implement and use chronic disease management registry (DMR) functionalities to enable a systematic and coordinated approach to caring for its patients with chronic diseases. Of the initial 50,000 patients covered by the CCC, 18,000 (36%) are expected to be patients with two or more chronic conditions. The DMR functionalities will be one component of the expanded health information technology (HIT) solution for CCC providers that will support disease management, analytics, patient care, care management interventions, and disease management. This intervention is one of a package of 14 DSRIP projects that transform the safety net health care system in Travis County, several of which provide clinical services to those with chronic disease. The other projects are:

- Patient Centered Medical Homes
- Chronic Care Management Models
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Telepsychiatry in Community Clinics
- Musculoskeletal Care in Community Clinics
- Community Paramedic Navigator Project
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- STD & HIV Screening and Treatment &

- Pregnancy Prevention Referrals

Taken together, all fourteen projects will improve patient health and the experience of care, and control healthcare costs as the CCC launches an ACO-like safety net care system.

Chronic diseases are characterized by gradually worsening symptoms that often do not manifest themselves until they are somewhat progressed. Once diagnosed, the diseases must be managed by the patient and caregiver on a daily basis. Individuals who do not have a medical home, however, are (1) more likely to be unaware of their condition and thus uneducated on the changes they need to make; (2) unlikely to be scheduled for follow-up appointments to monitor their health status; and (3) unlikely to receive referrals for specialty care or other support services. Individuals without a medical home also tend to access services wherever is affordable and convenient, primarily in the emergency department. Care for these individuals is made more difficult for providers unable to access real-time data on any diagnoses or care the individual may have received prior to their visit. Ensuring all patients have a medical home is being addressed by implementation of the Patient Centered Medical Home models, DSRIP project 307459301.2.1. This DSRIP project addresses information for the care teams.

The design of clinically-integrated DMR capabilities across the CCC contracted provider network will capture key administrative and clinical data on that subset of CCC patients with chronic conditions. The DMR capabilities will assist the provider care team to:

- Ensure that these patients receive the proper care at the appropriate time;
- Track the progress and outcomes of care to determine best practices;
- Identify the need for follow-up services;
- Empower patients to take an active role in their treatment; and
- Allow for risk-stratification to identify and target individuals with highest needs.

While the CCC contracted network of primary care provider teams will monitor, update, and evaluate these data on a regular basis, this information will be available to all providers within the CCC delivery network, including those involved in specialty, acute, and emergency care to help better inform treatment throughout the care continuum.

This project will build on the achievements of the Integrated Care Collaboration (ICC), a 501(c)3 non-profit formed by the community's safety net healthcare providers, around HIE design and implementation and care collaboratives. With the DMR functionalities enhanced and implemented throughout the network, the following benefits will be realized:

- There will be enhanced health care outcomes for the targeted patients.
- The patient/provider team encounter improve through use of care standards and access to timely, objective clinical care data.
- The larger community will benefit through more effective use of health care resources based on best care practices.

Goals and Relationship to Regional Goals:

Project Goals

The implementation and enhancement of DMR functions are proposed to help shift the alignment of health care in Travis County from a siloed, sick-care focus to an integrated well-care/prevention focus. The goal of implementing these DMR functions across the CCC network is to enhance the technological infrastructure that will support the management of care of patients with multiple chronic conditions to ensure that they receive the right care at the right time in the right place.

Specifically, the five year goals are to:

1. Roll out the functionalities to CCC providers;
2. Enroll at least 12,000 patients in the registry and generate reports based on their condition, activity, and the CCC's Chronic Care Models.
3. Ensure proper care for patients as enabled by the DMR functions, as demonstrated by increasing rates of critical monitoring & testing of the Category 3 improvement targets:
    a. Annual monitoring for patients on diuretics
    b. Annual retinal eye exams for diabetics
    c. Annual nephropathy screens for diabetics.

RHP Goals

This project aims to improve the health of individuals in Travis County with multiple chronic conditions through improved care coordination facilitated by electronic infrastructure development. This project will help meet the following regional goals:

RHP Goal 1: Prepare and develop infrastructure to improve the health of the current and future Region 7 population.

RHP Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

RHP Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

RHP Goal 4: Bolster individual and population health by improving chronic disease management.

Challenges:

There are a number of potential challenges in the development and implementation of enhanced DMR functions:

1. Registry Design. A number of design factors will need to be agreed-upon, including the initial population of the registry in terms of patients and data markers to be tracked for each chronic disease, where the registry will be housed and managed, the ability to adapt the registry for future needs or in response to lessons learned, legal issues of confidentiality, and frequency/types of system reports.
2. Interoperability with the CCC providers' various clinical information systems. Any DMR functions developed will need to interoperate and exchange data with the different EMR/HIE systems and existing in-house DMR systems to minimize impact to provider care workflow.
3. Data consistency. In order for data to be meaningfully collected and tracked across providers, there must be consistency in the data markers to be collected as well as how the data is measured and reported. This will ensure objectivity.
4. Maximizing Use of Registry. Consistent utilization of the registry by all CCC providers is key. Some provider teams will need to be convinced that the registry will aid their provision of care, be willing to adopt new care processes as needed, and be able to efficiently obtain and use information from the registry.

How this Project Addresses those Challenges

The resolution of each of these issues will be facilitated by the long history of collaboration among CCC contracted providers through their participation in the Integrated Care Collaborative, described above, which has already resulted in the development of a baseline HIE and some collaborative care programs. It will also be guided by federal meaningful use standards as established by the Office of the National Coordinator for Health Information Technology (ONC) and other identified best practices on DMR implementation.

5-Year Expected Outcome for Provider and Patients:

The 5-Year expected outcome for this project is the implementation of a fully integrated, standardized but flexible DMR which will allow the CCC to adequately aggregate clinical and administrative data on its most high-needs patients, facilitate patient navigation, inform health care treatment, and allow for risk stratification of patients. This project is expected to reduce complications related to chronic diseases for the 12,000 CCC patients with chronic conditions who will be enrolled by DY5. It will reduce complications by providing access to timely, coordinated data to allow for better controlling of health measures such as blood pressure as well as monitoring of successfulness of treatment interventions.

DYs 2 and 3 will be used to identify one or more target populations, determine current technology capabilities for each contracted provider, and identify cross-functional teams to coordinate functionality design and evaluation. The initial roll-out of the DMR functions will occur by the end of DY3. DYs 4 and 5 will expand the implementation and use of registry functionalities throughout the network, increase the number of patients in the directory, and enhance reporting capabilities.

Starting Point/Baseline:

Currently, system-wide DMR functionalities do not exist within the CCC. Therefore, the number of patients entered into the disease management registry DY2 is 0.

We anticipate entering at least 12,000 individuals into the registry over its first years of operations.

Rationale

The findings of the Community Needs Assessment for RHP 7 underscore the current and potential future impact of chronic disease on our residents if no changes are made to the current health care system and patient management of health status. The following data is in the CNA:

- Chronic conditions are the current leading causes of death in Region 7, and diabetes rates are rising across most counties.
- The percentage of Hispanics within Region 7 is projected to increase from 34% to approximately 41% in 2016. This demographic typically has higher rates of diabetes, obesity, and physical inactivity compared with Whites.
- The population throughout Region 7 is aging. Two of the fastest growing age groups in Travis County are adults age 45 to 64 and adults 65 and older. Rates of diabetes and other chronic diseases tend to become more prevalent with advancing age, and an older population will contribute to additional demand for healthcare resources.

Further, the Texas Department of State Health Services (DSHS) reports that between 2005 and 2010, there were 35,612 preventable hospitalizations in Travis County, at nearly $1 billion in charges. Most were for related to chronic conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), hypertension, and asthma. *(http://www.dshs.state.tx.us/ph/county.shtm)*

It is clear that a better way to manage the care of these individuals is needed to increase patient quality of life and reduce stress on the health care system through preventive care. The implementation and use of DMR functionalities across the CCC system will allow for more proactive, patient-focused, and collaborative care to help provide the right care, in the right place, at the right time.

Project Components:

The CCC is proposing to implement and enhance DMR functions to manage care for its target population with chronic conditions. This project will include all DSRIP-required core project components.

a) *Entering patient data into a unique chronic disease registry.* The specific conditions and health status markers to be tracked will be defined during the design process in DY2.
b) *Using registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, and family need.* Data will be integrated with the various EHR systems to facilitate access for provider care teams.
c) *Using registry reports to develop and implement targeted QI plans.* Reports will allow for tracking of impact of interventions as well as identification of implementation issues. The CCC will use data from all projects, analyze the effectiveness of interventions, and allocate future resources as needed.
d) *Conducting on-going QI projects by using methods such as rapid cycle improvement, etc.* Lessons learned will be shared and used to improve processes, with all CCC DSRIP projects.

Unique community need identification numbers the project addresses:

CN.7 Lack of coordination of care across settings of care, multiple conditions, and physical and behavioral health

CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

CN. 9 High rates of chronic disease such as: cardiovascular disease, cancer, diabetes

CN.10 Many residents in Region 7 have multiple chronic conditions

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

While Travis County has benefitted greatly from the work of the Integrated Care Collaborative, there remain limitations in the existing HIE system that will be resolved and enhanced through this project as well as through the CCC's Patient-Centered Medical Home project being proposed under Category 2. Limitations of the current system include –

- The need for providers to log out of their own EHR or other data system to log into the ICC system to access patient data from other providers.
- The limited amount of access to real-time clinical data that could inform the next steps in the care process.
- The need for a higher level of standardization across data systems that would address semantics in text fields, etc. to allow for easier and more accurate reporting.
- An enhanced cross-walking system to allow for greater bi-directionality of data flow.

The work to be done to implement the DMR functionalities and PCMH will address these issues and greatly facilitate the coordination of care across CCC's contracted network continuum.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

The CCC receives no DHHS funding.

Related Category 3 Outcome Measures:

Three category 3 outcomes were chosen from Outcome Domain 1, Primary Care and Chronic Disease Management.

IT-1.4: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – diuretic

IT-1.12 Diabetes care: Retinal eye exam (NQF 0055)

IT-1.14: Diabetes care: Microalbumin/Nephropathy (NQF 0062)

As noted above, DSHS reports that preventable hospitalizations in Travis County are most often related to diabetes, COPD, CHF and hypertension. Annual exams for patients on diuretics, as well as important annual exams for patients with diabetes, will help prevent these admissions.

Relationship to Other RHP Projects

The CCC's 14 projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to this project are outlined below.

List of Related Category 1 & 2 Projects

307459301.2.1: Patient-Centered Medical Home Project

307459301.2.3: Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients

307459301.1.8: Telepsychiatry in Federally Qualified Primary Health Clinics

307459301.2.4: Sexually Transmitted Disease Screening, Treatment, and Prevention

List of Related Category 4 Projects

RD-1. Potentially Preventable Admissions (1-8)

RD-2.7. All-Cause: 30-Day Readmissions

RD-4.2. Patient Satisfaction

RD-5. Emergency Department – admit decision time to ED departure time for admitted patients

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

137265806.2.6: Chronic Care Management: Adults

137265806.2.9: Adult diabetes inpatient chronic care management

133542405.2.5: Implementation of Chronic Disease Prevention/ Management Models

201320302.2.2: Expansion of Community Diabetes Project

137265806.2.6: Chronic Care Management: Adults

137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will create regular opportunities to share ideas and solve problems, including bi-annual, region-wide meetings, conference calls, on-going use and updating of the RHP 7 website, and smaller, topical meetings as needed to share information, updates and best practices. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Within the CCC, providers will meet at least monthly to discuss implementation and operation issues associated with the DMR project and other data analysis and IT-related projects.

Project Valuation:

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.1	***RHP PP REFERENCE NUMBER: 1.3.1***	***PROJECT COMPONENTS: 1.3.1 (A-D)***	***PROJECT TITLE: IMPLEMENT/ENHANCE AND USE CHRONIC DISEASE MANAGEMENT REGISTRY FUNCTIONALITIES: THE COMMUNITY CARE COLLABORATIVE DISEASE MANAGEMENT REGISTRY FUNCTIONALITIES PROJECT***	
Performing Provider Name: Community Care Collaboration				*307459301.1.1*
Related Category 3 Outcome Measure(s):	*307459301.3.24* *307459301.3.25* *307459301.3.26*	*IT 1.4* *IT 1.12* *IT 1.14*	*IT-1.4: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – diuretic* *IT-1.12 Diabetes care: Retinal eye exam (NQF 0055)* *IT-1.14: Diabetes care: Microalbumin/Nephropathy (NQF 0062)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Identify one or more target patient populations diagnosed with selected chronic disease(s) or multiple chronic conditions Metric 1 [P-1.1]: Documentation of patients to be entered into the registry Goal: In conjunction with CCC's Chronic Disease Management Model DSRIP Project (see 307459301.2.2) identify most appropriate patient groups for enrollment. Data Source: Performing Providers Records/Documentation Milestone 1 Estimated Incentive Payment: $1,373,492 **Milestone 2** [P-2]: Review current registry capability and assess future needs Metric 1 [P-2.1]: Documentation of review of current registry capability and assessment of future registry needs Goal: Take inventory of current DMR capabilities within CCC and its providers. Produce report with gap analysis. Data Source: EHR systems and/or other provider documentation **Milestone 2** Estimated Incentive Payment: $1,373,492	**Milestone 5** [P-4]: Implement a functional disease management registry. Metric 1 [P-4.1]: Documentation of adoption, installation, upgrade, interface or similar documentation Goal: Enhance all providers' existing EHR to offer CCC's DMR functionalities for identified MCCs. Data Source: Protocols; user guides; screen shots. **Milestone 5** Estimated Incentive Payment: $1,014,857 **Milestone 6** [P-6]: Conduct staff training on populating and using registry function Metric 1 [P-6.1]: Documentation of training programs and list of staff members trained, or other similar documentation Goal: Train certain staff members to use DMR functions; then those staff train their peers in turn. Data Source: Training program materials; sign in sheets; feedback forms. **Milestone 6** Estimated Incentive Payment: $1,014,858	**Milestone** 9 [P-14]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: 2 per year Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes **Milestone** 9 Estimated Incentive Payment: $1,653,277 **Milestone 10:** [I-15]: Increase the percentage of patients enrolled in the registry Metric 1 [P-15.1]: Percentage of patients in registry Baseline/Goal: Baseline/Goal: 0 patients are enrolled in CCC DMR in DY2; 3,000 will be enrolled by end of DY3/7,000 total patients enrolled in DMR by end of DY4 – 4,000 additional patients in DY4. Data Source: Registry or EHR; CCC patient records **Milestone 10** Estimated Incentive Payment: $1,653,277	**Milestone** 12[P-14]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: 2 per year Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes **Milestone** 12 Estimated Incentive Payment: $ 1,001,504 **Milestone** 13 [I-19]: Spread registry functionality throughout Performing Provider facilities Metric 1 [P-19.1]: Increase number of clinics/sites associated with Performing Provider's facility that are providing continuity of care for defined population using disease registry Goal: 90% of facilities will use DMR Data Source: Registry reports **Milestone** 13 Estimated Incentive Payment: $ 1,001,504

Milestone 3 [P-3]: Develop cross-functional team to evaluate registry program Metric 1 [P-3.1]: Documentation of personnel assigned to evaluate registry program. Goal: Bring together all levels of care team providers, IT specialists and planners to evaluate current capabilities. Data Source: Team Roster **Milestone 3** Estimated Incentive Payment: $1,373,492 **Milestone 4** [P-14]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: One meeting in DY2 due to its shortened length. Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes **Milestone 4** Estimated Incentive Payment: $1,373,491	**Milestone 7** [P-14]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: 2 per year Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes **Milestone 7** Estimated Incentive Payment: $ 1,014,858 **Milestone 8:** [I-15]: Increase the percentage of patients enrolled in the registry Metric 1 [P-15.1]: Percentage of patients in registry Baseline/Goal: 0 patients are enrolled in CCC DMR in DY2/3,000 patients enrolled in DMR by end of DY3 Data Source: Registry or EHR; CCC patient records **Milestone 8** Estimated Incentive Payment: $1,014,858	**Milestone** 11 [I-19]: Spread registry functionality throughout Performing Provider facilities Metric 1 [P-19.1]: Increase number of clinics/sites associated with Performing Provider's facility that are providing continuity of care for defined population using disease registry Goal: 50% of facilities will use DMR Data Source: Registry reports **Milestone** 11 Estimated Incentive Payment $1,653,277	**Milestone** 14 **:** [I-15]: Increase the percentage of patients enrolled in the registry Metric 1 [P-15.1]: Percentage of patients in registry Baseline/Goal: Baseline/Goal: 0 patients are enrolled in CCC DMR in DY2; 7,000 will be enrolled by end of DY5/12,000 total patients enrolled in DMR by end of DY5 – 5,000 additional patients in DY5.Data Source: Registry or EHR **Milestone** 14 Estimated Incentive Payment: $ 1,001,505 **Milestone** 15 [I-20]: Generate registry-based reports for each provider/care team for the care delivered outside of the office visit Metric 1 [I-20.1]: Increase or achieve the number of reports sent out to a number or percent of primary care providers over 12 month period Baseline/Goal: To be determined in DY2 Data Source: Registry and/or EHR **Milestone** 15 Estimated Incentive Payment: $ 1,001,505
Year 2 Estimated Milestone Bundle Amount: $5,493,967	Year 3 Estimated Milestone Bundle Amount: $5,074,289	Year 4 Estimated Milestone Bundle Amount: $4,959,831	Year 5 Estimated Milestone Bundle Amount: $4,006,018
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $19,534,105**			

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Performing Provider: Community Care Collaborative

Project Name: Expanded Primary Care Hours at Community-Based Outpatient Settings

Project Identifier: 307459301.1.2 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will expand primary care access through evening and weekend hours at targeted clinic locations in the CCC provider network. In addition, this project will expand primary care access through the opening of the new Southeast Health and Wellness Center in DY4. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project will provide a medical home for low-income patients who are at risk of using the Emergency Department (ED) for non-emergent medical issues.

Need for the project: A limited number of existing community-based outpatient clinics offer appointments after 5:00 PM. An analysis of ED visits by uninsured and underinsured patients in Travis County shows that many patients continue to utilize the ED for non-emergent visits throughout the evening, as late as 11:00 PM. This project will provide a medical home and access to care for low-income patients who are at risk of using the ED for non-emergent medical issues.

Southeast Travis County, home to the proposed Southeast Health and Wellness Center, has consistently been identified as an area with high levels of poverty and limited healthcare infrastructure. Approximately 46% of the surrounding population lives below 200% of the Federal Poverty Level.

Target population: The CCC will cover approximately 50,000 patients at or below 200% FPL. These patients, and others who need to use the system, will be able to access clinic services through expanded hours.

Category 1 or 2 expected patient benefits: Through this project, the CCC expects an increase of 5,000 primary care visits in DY3, 21,000 primary care visits in DY4, and 49,000 primary care visits in DY5. By DY5, this project will serve approximately 16,000 patients annually.

Category 3 outcomes: IT-9.2 – ED appropriate utilization. Baseline rates and percentage improvement targets will be set in DY2 and DY3.

Title of Project: Expanded Primary Care Hours at Community-Based Outpatient Settings

Category / Project Area / Project Option: 1.1.2 Expand existing primary care capacity

RHP Project Identification Number: 307459301.1.2 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will expand primary care access for underserved Travis County residents through extended clinic hours, staffing, and service locations. These patients will benefit from increased access as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project

The CCC provider network will include more than 30 community-based outpatient clinics located in low-income areas throughout Travis County. While selected clinics offer extended hours, approximately 80% of these clinics are currently open only Monday through Friday from 8:00 AM to 5:00 PM, with no evening or weekend appointments available. This project will establish evening and weekend hours at additional clinic locations in the CCC provider network. After-hours appointments will include a dynamic mix of scheduled routine primary care visits and walk-in acute care capacity. Scheduling will be responsive to the needs of the local community, with adjusted availability of appointment types throughout the year to accommodate periodic fluctuations in demand, such as school physicals or seasonal allergies.

Expanded access will be accomplished by contracting with and/or hiring additional primary care physicians, nurse practitioners and support staff. In addition, this project will expand primary care access as Travis County's renovated Southeast Health and Wellness Center which is expected to open in late 2014. The center will become a key service site in the CCC's constellation of community-based outpatient clinics where our contracted providers will offer multi-disciplinary, integrated care to low-income residents of Travis County. A portion of this DSRIP project will be dedicated to planning and renovating this existing medical facility (currently occupied by the VA) to meet the needs of these patients and provide them with care that emphasizes whole health, prevention, and wellness.

Project Goals:

- Incrementally increase access to primary care appointments;
- Provide a medical home for low-income patients who are at risk of using the Emergency Department (ED) for non-emergent medical issues;
- Reduce unnecessary ED visits;
- Improve patient satisfaction;
- Improve management of chronic conditions.

How the Project is Related to RHP Goals

This project supports the following RHP goals:

- Goal 1 - Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
- Goal 2 - Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Challenges or Issues Faced by the Performing Provider

Recruiting providers and support staff, particularly those willing to work evenings and/or weekends, may be a challenge. It may also prove difficult to alter behavior patterns for patients accustomed to utilizing the ED for routine primary care. A 2012 analysis of uninsured and underinsured patients in Travis County found that approximately 50% of ED visits provided during regular clinic hours (8:00 AM-5:00PM on weekdays) did not require immediate care or could have been provided effectively and safely in a primary care setting. Many of these patients lived within 2 miles of an existing community-based outpatient clinic but still chose to utilize the ED instead. In addition, patients living in close proximity to existing outpatient clinics with extended hours continued to visit the ED for non-emergent medical issues during evening hours when these clinics would have been open.

How the Project Addresses those Challenges

In order to ensure appropriate staffing, the CCC will offer financial or other incentives as needed to recruit qualified providers and support staff to work during extended hours. To encourage patients to take advantage of expanded hours, the CCC will advertise new hours through mailers to existing patients and flyers in clinic lobbies and waiting rooms as well as local EDs. Patient education will include information about appropriate emergency department utilization and examples of health conditions which can be treated effectively and safely in a primary care setting.

Patients presenting to the ED for routine primary care will receive information from ED personnel about nearby clinics which offer extended hours. The CCC's related Community Paramedic Patient Navigation Program (Project ID 307459301.2.6) will reinforce this project by helping to connect frequent utilizers to appropriate primary care services.

5-Year Expected Outcome for Providers and Patients: Through this project, the CCC expects an increase 5,000 primary care visits in DY3, 21,000 primary care visits in DY4, and 49,000 primary care visits in DY5. By DY5, this project will serve approximately 16,000 patients annually. This project addresses core components A through C to expand primary care clinic space, hours, and staffing, as outlined in the Rationale section below. With this increased primary care access, the CCC aims to reduce unnecessary ED visits, improve patient satisfaction, and improve management of chronic conditions.

Starting Point/Baseline

Baseline Data: Within the CCC, CommUnityCare operates the largest network of Federally Qualified Health Centers in Travis County. In Fiscal Year 2012 (October 2011 – September 2012), CommUnityCare provided approximately 200,000 primary care medical visits. During DY2, the CCC will establish a more comprehensive baseline of visits across all providers, including an analysis of after-hours utilization.

Rationale

Reason for Selection of Project Options and Components

An analysis of ED visits by uninsured and underinsured patients in Travis County shows that many patients continue to utilize the ED for non-emergent visits throughout the evening, as late as 11:00 PM. Expanding clinic hours will give patients additional choices for when and where they can access care and will help reduce barriers for low-income patients who cannot afford to miss work or school.

A December 2012 analysis published by *Health Affairs* found that patients with access to after-hours care had significantly fewer ED visits, compared with those who experienced more difficulty contacting a clinician after-hours (30.4 percent compared to 37.7 percent). Patients reporting poor health status as well as patients with no insurance or coverage through Medicaid or CHIP were significantly more likely to have difficulty contacting a clinician after-hours. Finally, patients who reported less difficulty contacting a clinician after-hours had lower rates of unmet medical need in the last twelve months (O'Malley, Ann S. *After-Hours Access to Primary Care Practices Linked With Lower Emergency Department Use and Less Unmet Medical Need.* Health Affairs, 2012).

Within Travis County, a 2011 analysis of ED visits by uninsured and underinsured patients found that almost 25% of ED visits did not require treatment within 12 hours. An additional 24% of visits required treatment within 12 hours, but care could have been provided effectively and safely in a primary care setting. Approximately 6% of ED visits required emergent care but were potentially preventable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.).

A subsequent 2012 analysis found that over 42,000 uninsured and underinsured patients in Travis County had one or more visits at local EDs but had no recorded visits at community-based outpatient clinics during the 12 months ending on April 30, 2012. Expanded primary care access is essential as the CCC seeks to influence patient behavior by shifting care to the most appropriate and cost-effective setting.

Improved access also will be important as the CCC focuses on patients with multiple chronic conditions who often require multiple appointments and longer visits. Approximately 20% of uninsured and underinsured patients in Travis County have two or more chronic conditions, and better primary care access will help reduce the likelihood that these conditions develop into acute episodes requiring costly emergency or inpatient care.

Southeast Travis County, home to the proposed Southeast Health and Wellness Center within this project, has consistently been identified as an area with high levels of poverty and limited healthcare infrastructure. Approximately 270,000 people reside within a 5-mile radius of the new Southeast Health and Wellness Center, and 46% live below 200% of the Federal Poverty Level. The CCC's related Mobile Primary Care project (Project ID 307459301.1.3) will further enhance this project by extending additional services to geographically underserved patients in more rural areas of Travis County and to those with transportation barriers to accessing care.

This project includes three core project components:

A) Expand primary care clinic space: The new Southeast Health and Wellness Center is scheduled to open in 2014 to expand primary care clinic capacity in Southeast Travis County. This 68,000 square foot medical facility formerly operated by the Department of Veterans Affairs will be renovated and modernized to provide multi-disciplinary, integrated care to low-income uninsured and underinsured residents. Additional planning activities for this project component will take place during DY2.

B) Expand primary care clinic hours: This project will establish evening and weekend hours at additional clinic locations in the CCC provider network. After-hours appointments will include a dynamic mix of scheduled routine primary care visits and walk-in acute care capacity. Project planning during DY2 will identify targeted clinic locations for expanded hours. Initially, this project will expand hours to 8:00 PM; a pilot program will evaluate the feasibility of longer hours (up to 11:00 PM) at specific locations.

C) Expand primary care clinic staffing: The CCC will contract with and/or hire additional primary care physicians, nurse practitioners and support staff to provide care at the new Southeast Health and Wellness Center and during expanded hours at existing clinics. Project planning during DY2 will further identify future staffing requirements.

Reason for Selection of Milestones & Metrics

DY2 reflects project planning (P-X), including an analysis to identify targeted clinic locations for expanded hours and a plan for the development of the Southeast Health and Wellness. In order to increase primary care capacity,

DYs 3 and 4 include process milestones P-4, P-5, and P-1 to hire staff, increase clinic hours, and open the new Southeast Health and Wellness Center. Improvement milestones in DYs 3 through 5 will demonstrate improved access to primary care, including increased primary care visits (I-12). In addition, the CCC will document lessons learned in order to develop new methodologies or refine existing ones (P-X).

Unique Community Need Identification Number

- CN.1 – Inadequate access to primary care
- CN.8 - High rates of non-emergent emergency department usage and potentially preventable inpatient admissions
- CN.9 – High rates of chronic disease

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

A limited number of existing community-based outpatient clinics offer appointments after 5:00 PM. This project will establish evening and weekend hours at additional clinic locations in the CCC provider network. Scheduling will be responsive to the needs of the local community, with adjusted availability of appointment types throughout the year to accommodate periodic fluctuations in demand, such as school physicals or seasonal allergies.

This project also enhances the capacity of the existing delivery system by renovating the existing Veterans Affairs Clinic for future use as the Southeast Health and Wellness Center. This clinic is strategically located to provide care to low-income residents in an underserved area of Travis County.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected:

OD-9: Right Care, Right Setting

IT-9.2 – ED appropriate utilization (standalone measure)

Reasons/Rationale for Selecting the Outcome Measure(s)

As indicated above, low-income patients have limited options for after-hours primary care, and uninsured and underinsured patients in Travis County frequently utilize local EDs for non-emergent medical issues.

By increasing access to primary care, including after-hours availability, this project aims to reduce unnecessary ED utilization (IT-9.2) by shifting care to the most appropriate and cost-effective setting. In addition, improved chronic care management will reduce the likelihood that these conditions develop into acute episodes requiring emergency or inpatient care.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's fourteen projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Expanded Primary Care Hours at Community-Based Outpatient Settings are outlined below.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

- 307459301.1.3: Mobile Primary Care
- 307459301.1.4: Expansion of Dental Services
- 307459301.1.8: Telepsych in Federally Qualified Primary Health Clinics
- 307459301.2.1: Patient-Centered Medical Home Project
- 307459301.2.6: Community Paramedic Patient Navigation Program

List of Related Category 4 Projects

RD-1: Potentially Preventable Admissions

Relationship to Other Performing Clinics' Projects in the RHP

Central Texas Medical Center is proposing a similar intervention (Project ID 121789503.1.1) to expand primary care hours and capacity for uninsured and underinsured residents in Hays County, approximately 30 miles south of Austin. With its aim to improve management of chronic conditions, this project also has a similar target population to University Medical Center Brackenridge's Chronic Care Management for Adults (137265806.2.6) and ATCIC's project to Integrate Primary and Behavioral Health Care Services (133542405.2.1).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health as RHP 7's anchor, will foster the development of topical learning collaborative; e.g. smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are

involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.2	***1.1.2***	***1.1.2A THROUGH C***	***EXPANDED PRIMARY CARE HOURS AT COMMUNITY-BASED OUTPATIENT SETTINGS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.2*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Conduct a needs/gap analysis, in order to inform the establishment or expansion of services/programs Metric 1 [P-X]: Conduct an analysis to identify clinic locations for expanded hours Data Source: Planning documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,424,944 **Milestone 2** [P-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development	**Milestone 4** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of hours at a primary care clinic over baseline. Baseline: 40 hours/week at clinic locations targeted for expanded hours Goal: 55 hours/week at each clinic location targeted for expanded hours (minimum of 3 locations) Data Source: Clinic Schedule Milestone 4 Estimated Incentive Payment: $ 1,316,094		**Milestone 7** [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Data Source: Documentation of new Southeast Health and Wellness Center Milestone 7 Estimated Incentive Payment: $ 964,806 **Milestone 8** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Data Source: Clinic Documentation	**Milestone 11** [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: TBD Goal: Increase of 49,000 visits over baseline Data Source: Clinic Encounter Data Milestone 11 Estimated Incentive Payment: $ 1,558,533

307459301.1.2	***1.1.2***	***1.1.2A THROUGH C***	***EXPANDED PRIMARY CARE HOURS AT COMMUNITY-BASED OUTPATIENT SETTINGS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.2*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-X] Develop a plan for the new Southeast Health and Wellness Center to include utilization analysis, evidenced-based best design practice, and clinical needs of population Data Source: Planning documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 1,424,944 **Milestone 3** [P-X]: Establish a baseline, in order to measure improvement over self Metric 1 [P-X]:	**Milestone 5** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Data Source: Clinic Documentation Milestone 5 Estimated Incentive Payment: $ 1,316,094 **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.		Milestone 8 Estimated Incentive Payment: $ 964,806 **Milestone 9** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: TBD Goal: Increase of 21,000 visits over baseline Data Source: Clinic Encounter Data Milestone 9 Estimated Incentive Payment: $ 964,806 **Milestone 10** [P-X]: Develop a new	**Milestone 12** [P-X]: Develop a new methodology, or refine an existing one, based on learnings Metric 1 [P-X]: Document lessons learned and how applied to new or existing methodologies Data Source: Clinic Documentation Milestone 12 Estimated Incentive Payment: $ 1,558,532

307459301.1.2	***1.1.2***	***1.1.2A THROUGH C***	***EXPANDED PRIMARY CARE HOURS AT COMMUNITY-BASED OUTPATIENT SETTINGS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.2*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Establish comprehensive baseline of primary care visits across all CCC providers Data Source: Clinic Encounter Data Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 1,424,944	Demonstrate improvement over prior reporting period. Baseline: TBD Goal: Increase of 5,000 visits over baseline Data Source: Clinic Encounter Data Milestone 6 Estimated Incentive Payment: $ 1,316,094		methodology, or refine an existing one, based on learnings Metric 1 [P-X]: Document lessons learned and how applied to new or existing methodologies Data Source: Clinic Documentation Milestone 10 Estimated Incentive Payment: $ 964,805	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 4,274,832	Year 3 Estimated Milestone Bundle Amount: $ 3,948,282		Year 4 Estimated Milestone Bundle Amount: $ 3,859,223	Year 5 Estimated Milestone Bundle Amount: $ 3,117,065
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $ 15,199,402**				

Performing Provider: Community Care Collaborative

Project Name: Expand Primary Care Capacity via Mobile Health Clinics

Project Identifier: 307459301.1.3 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will expand primary care to underserved areas of Travis County and Austin through three mobile health clinics that provide scheduled and same day appointments for comprehensive primary care. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project extends services to geographically isolated patients in more rural areas of the county and to those with transportation barriers to accessing care.

Need for the project: Travis County has pockets of great need, including areas in the East, Southeast, and Northeast, and Northwest portions of the county, where little primary care is available. Even in areas where more primary care is available, transportation challenges, especially for low-income residents, mean limited access to healthcare services.

Target population: The CCC's covered population will be approximately 50,000 patients at or below 200% of the FPL, many of whom will have chronic conditions. This project will target geographically underserved populations, including low-income residents with transportation barriers that limit access to primary care.

Category 1 or 2 expected patient benefits: Through the use of mobile health clinics, the CCC expects to provide approximately 1,300 visits in DY3, 3,300 visits in DY4, and 4,800 annual visits in DY5. By DY5, this project will serve approximately 1,600 patients per year. This project aims to increase access to timely care, improve patient satisfaction, and improve management of chronic conditions.

Category 3 outcomes:

- IT-1.7 Controlling High Blood Pressure
- IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression
- IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)
- Baseline rates and percentage improvement target will be set in DY2 and DY3.

Title of Project: Expand Primary Care Capacity via Mobile Clinics

Category / Project Area / Project Option: 1.1.3

RHP Project Identification Number: 307459301.1.3 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will use the flexibility of mobile health clinics (MHCs) to expand primary care to Travis County's geographically underserved populations. These patients will benefit from increased access as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project

Through the purchase, outfitting and dispatch of three MHCs, this project will reach patients who reside in areas without reliable access to care. Comprehensive primary care will include services for the elderly, children, and

pregnant women; chronic disease management; on site basic blood tests and urinalysis; health risk screenings; and referral to behavioral health and social services.

The MHCs, staffed with a physician, nurse and clinical assistant, and an assistant with a Commercial Driver's License, will stop at specific locations on a pre-determined schedule and will see a combination of scheduled and same-day appointments. The locations for service may include public schools, shopping malls, public libraries, and banks, and the vans will be in operation four days a week.

The MHCs deployed by the CCC can serve as a medical home for patients without one and can refer patients with healthcare needs that require more resource-rich care to another appropriate CCC facility. A 2012 report developed for John Muir/Mt. Diablo Community Health Fund and the East and Central County Health Access Action Team in Contra Costa County, California, found that 40 to 80% of patients treated the mobile clinic as their medical home (http://www.johnmuirhealth.com/content/dam/jmh/ Documents/Community/Mobile_Health_Clinics-Increasing_Access_to_Care.pdf) The CCC expects that patients with multiple chronic conditions, previously isolated from regular care sources by their geographic location, will improve the management of their conditions by having regular access to MHCs.

Of the 50,000 patients within the CCC, an estimated 18,000 have multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes. This Mobile Health Clinics project will increase access to care for these sickest patients closer to their homes, so that their conditions do not worsen to the point of needing hospitalization.

Project Goals

By DY5, the Project will:

- Deploy three mobile health clinics to underserved areas and populations of Travis County.
- Offer 576 new clinic days per year in DY5
- Offer approximately 4,800 annual visits by DY5
- Improve patient satisfaction
- Improve management of chronic conditions

How the Project is Related to RHP Goals

This project is related to the following RHP 7 Goals:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Challenges or Issues Faced by the Performing Provider

Mobile units require a fair amount of in-place infrastructure, which include: wastewater processing; restroom facilities; a waiting area; charging stations; internet access for electronic health records. Despite limited infrastructure in most targeted locations, sites will need to be identified that will allow the MHCs to provide services on an ongoing basis. Patients will need to be informed of the new services through appropriate channels, and made aware

of the MHCs' schedules. Finally, recruiting providers and support staff, particularly those willing to work in a mobile clinic environment, may be a challenge.

How the Project Addresses those Challenges

The CCC will utilize its existing relationships with safety net providers, social service organizations, and city and county agencies to identify and secure appropriate sites for MHCs. To encourage patients to take advantage of available appointments through MHCs, the CCC will advertise MHC locations and schedules through flyers in existing clinic lobbies and waiting rooms as well as through local emergency departments, as well as in those areas where clinics will be deployed. Category 1 improvement milestones assume that MHCs will operate at approximately 50% capacity initially as the CCC continues to establish awareness within the community.

In order to ensure appropriate staffing, the CCC will offer financial or other incentives as needed to recruit qualified providers and support staff to work in a mobile clinic environment. To minimize staffing future costs, existing medical assistants may be cross-trained to receive a Commercial Driver's License.

5-Year Expected Outcome for Providers and Patients

Through the use of mobile health clinics, the CCC expects to provide approximately 1,300 visits in DY3, 3,300 visits in DY4, and 4,800 annual visits in DY5. By DY5, this project will serve approximately 1,600 patients per year. This project aims to increase access to timely care, improve patient satisfaction, and improve management of chronic conditions.

Starting Point/Baseline

Baseline Data: Within Travis County, existing mobile health clinics provide targeted pediatric and dental health services. However, there are no mobile clinics offering the described medical home services to the CCC patient population at this time.

Time Period for Baseline: 2012

Rationale

Reason for Selection of Project Options and Components

A 2011 analysis developed for Central Health evaluated demographic characteristics to identify geographic areas of need throughout Travis County. Families living below 100% of the Federal Poverty Level are concentrated primarily in the East, Southeast, and Central areas of Travis County.

While poverty is relatively sparse in the western half of Travis County, the far Northwest area also demonstrates high levels of need. This geographically isolated area is designated as a Primary Care Health Professional Shortage Area (HPSA) by the Department of Health and Human Services Health Resources and Services Administration. West and Northwest Travis County also include the greatest concentration of seniors ages 65 and older, who often have barriers to transportation.

In addition to current concentrations of need, data from Nielsen (formerly Claritas) evaluate historical population patterns as well as housing costs and construction trends to project future geographic shifts. Rising property values in Central Austin are forcing lower income families to relocate to the suburbs and more rural areas, with growth primarily in the East, Southeast, and Northeast parts of the county.

Development in these outlying areas is less densely populated than within the traditional urban core. A lack of transportation and other infrastructure presents challenges for adequate access to healthcare services, yet expected patient volumes are typically too low to support a standalone clinic.

A subsequent 2012 analysis developed for Central Health evaluated uninsured and underinsured patients in Travis County who accessed services at local hospitals but had no recorded visits at community-based outpatient clinics. This analysis identified several pockets of need that were isolated from current healthcare safety net clinics, including:

- East and Southeast Travis County - Austin Colony and River Timber areas
- South Central Travis County - Manchaca area
- Southwest and Northwest Travis County - Greater Hudson Bend area
- Northwest Travis County - Anderson Mill and Fulkes Lane areas
- Northeast Travis County – East Pflugerville area

Transportation barriers also exist for patients who live in the urban core. As detailed in the Austin/Travis County 2012 Community Health Assessment, which drew heavily from focus groups and resident surveys, transportation challenges, especially for low-income residents, mean limited access to healthcare services. (http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/cha_report_8-24-12.pdf, p. vii)

Reason for Selection of Milestones & Metrics

DY2 reflects project planning (P-X) for implementation of a MHC program, including identification of potential locations that can accommodate mobile vans. In order to increase primary care capacity, DYs 3 and 4 include process milestones P-3 and P-5 to establish new MHCs and hire appropriate staff. Improvement milestones in DYs 3 through 5 will demonstrate improved access to primary care, including increased primary care visits and unique patients (I-12).

Unique Community Need Identification Number

- CN.1 - Inadequate access to primary care
- CN.5 – Transportation access for people in the rural areas and also for low-income populations in urban areas
- CN.8 – High rates on non-emergent emergency room department usage and potentially preventable inpatient admissions.

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

This is a new initiative for the CCC.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-1: Primary Care and Chronic Disease Management

- IT-1.7 Controlling High Blood Pressure
- IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression
- IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)

Reasons/Rationale for Selecting the Outcome Measure(s)

As indicated above, low-income residents in Travis County are increasingly located in suburbs and other rural areas with limited access to transportation and other infrastructure. Transportation challenges, especially for low-income residents, also limit access to healthcare services within the urban core.

According to a recent Community Health Assessment completed for Travis County, heart disease is one of the leading causes of death for Travis County residents. Diabetes is the 7th leading cause of death in Travis County according to the same study. The need for mental health services was also the foremost community health concern raised by residents. All of these conditions contribute to potentially preventable hospitalizations. Within the CCC, these three chronic diseases are among those conditions to be aggressively targeted for improved health outcomes. These conditions can be treated and managed by regular medical visits, and the CCC hopes to drive more expensive hospital and emergency room treatment of these conditions back into the community setting. These two reasons informed the choice of the three outcomes for Mobile Health Clinic.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's fourteen projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Expanded Primary Care Capacity via Mobile Health Clinics are outlined below.

While other projects will expand services in community-based outpatient settings, the MHC project will reach beyond the brick and mortar model to extend services to geographically underserved patients in more rural areas of the county and to those with transportation barriers to accessing care. Coordination with providers throughout the CCC will be essential to accommodate patients who require services beyond the scope of the MHC.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.4 : Expansion of Dental Services
- 307459301.1.5: Expanded Specialty Care at Community-Based Outpatient Settings: Musculoskeletal
- 307459301.1.6: Expanded Specialty Care at Community-Based Outpatient Settings: GI
- 307459301.1.7: Expanded Specialty Care at Community-Based Outpatient Settings: Pulmonology
- 307459301.1.8: Telepsych in Federally Qualified Primary Health Clinics

List of Related Category 4 Projects

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Central Texas Medical Center is proposing expanded primary care hours and capacity for uninsured and underinsured residents in Hays County (Project ID 121789503.1.1). In addition, this project offers a similar intervention to other mobile projects, laying the groundwork for a potential learning collaborative. These projects include ATCIC's Mobile Crisis Outreach Team (133542405.2.2), Hill Country MHDD's Hays County Mental Health Center Mobile Clinic (133340307.1.1), and the University Medical Center at Brackenridge Women's Oncology Care Screening (137265806.2.2).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health as RHP 7's anchor, will foster the development of topical learning collaborative; e.g. smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development Metric 1 [P-X] Develop a plan for implementation of a mobile health clinic program, including identification of potential locations Data Source: Planning documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,220,310	**Milestone 2** [P-3]: Implement/expand a mobile health clinic program Metric 1 [P-3.1]: Number of additional clinics or expanded hours or space Baseline: 0 Mobile Health Clinics Goal: 2 Mobile Health Clinic operational by end of year Data Source: Clinic schedule Milestone 2 Estimated Incentive: $375,698 **Milestone 3** [P-5]: Train/hire additional primary care providers and staff	**Milestone 5** [P-3]: Implement/expand a mobile health clinic program Metric 1 [P-3.1]: Number of additional clinics or expanded hours or space Baseline: 2 Mobile Health Clinics Goal: 3 Mobile Health Clinic operational by end of year Data Source: Clinic schedule Milestone 5 Estimated Incentive: $367,223 **Milestone 6** [P-5]: Train/hire additional primary care providers and staff	**Milestone 8** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 visits in 2012 Goal: 4,800 visits in DY5 Data Source: Clinic Encounter Data Metric 2 [I-12.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period.

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: 0 Mobile Health Clinic Staff Goal: 2 physicians, 2 nurses, and 2 clinical assistants Data Source: Clinic Documentation Milestone 3 Estimated Incentive Payment: $375,697 **Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.	Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: 0 Mobile Health Clinic Staff Goal: 3 physicians, 3 nurses, and 3 clinical assistants (increase of 1 physician, 1 nurse, and 1 clinical assistant over DY3) Data Source: Clinic Documentation	Baseline: 0 patients in 2012 Goal: 1,600 patients in DY5 Data Source: Clinic Encounter Data Milestone 8 Estimated Incentive Payment: $ 889,809

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 visits in 2012 Goal: 1,300 visits in DY3 Data Source: Clinic Encounter Data Milestone 4 Estimated Incentive Payment: $375,697		Milestone 6 Estimated Incentive Payment: $367,223 **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: 0 visits in 2012 Goal: 3,300 visits in DY4 Data Source: Clinic Encounter Data Metric 2 [I-12.2]: Documentation of	

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	
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			increased number of unique patients. Demonstrate improvement over prior reporting period. Baseline: 0 patients in 2012 Goal: 1,100 patients in DY4 Data Source: Clinic Encounter Data Milestone 7 Estimated Incentive Payment: $367,222	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 1,220,310	Year 3 Estimated Milestone Bundle Amount: $ 1,127,092		Year 4 Estimated Milestone Bundle Amount: $ 1,101,668	Year 5 Estimated Milestone Bundle Amount: $ 889,809
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* **$ 4,338,879**				

Performing Provider: Community Care Collaborative

Project Name: Expand Primary Care Capacity via Mobile Health Clinics

Project Identifier: 307459301.1.3 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will expand primary care to underserved areas of Travis County and Austin through three mobile health clinics that provide scheduled and same day appointments for comprehensive primary care. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project extends services to geographically isolated patients in more rural areas of the county and to those with transportation barriers to accessing care.

Need for the project: Travis County has pockets of great need, including areas in the East, Southeast, and Northeast, and Northwest portions of the county, where little primary care is available. Even in areas where more primary care is available, transportation challenges, especially for low-income residents, mean limited access to healthcare services.

Target population: This project will target geographically underserved populations, including low-income residents with transportation barriers that limit access to primary care. The majority of these patients are uninsured or on Medicaid and are at or below 200% of FPL.

Category 1 or 2 expected patient benefits: Through the use of mobile health clinics, the CCC expects to provide approximately 1,300 visits in DY3, 3,300 visits in DY4, and 4,800 annual visits in DY5. By DY5, this project will serve approximately 1,600 patients per year. This project aims to increase access to timely care, improve patient satisfaction, and improve management of chronic conditions.

Category 3 outcomes:

- IT-1.7 Controlling High Blood Pressure
- IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression
- IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)
- Baseline rates and percentage improvement target will be set in DY2 and DY3.

Title of Project: Expand Primary Care Capacity via Mobile Clinics

Category / Project Area / Project Option: 1.1.3

RHP Project Identification Number: 307459301.1.3 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will use the flexibility of mobile health clinics (MHCs) to expand primary care to Travis County's geographically underserved populations. These patients will benefit from increased access as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project

Through the purchase, outfitting and dispatch of three MHCs, this project will reach patients who reside in areas without reliable access to care. Comprehensive primary care will include services for the elderly, children, and pregnant women; chronic disease management; on site basic blood tests and urinalysis; health risk screenings; and referral to behavioral health and social services.

The MHCs, staffed with a physician, nurse and clinical assistant, and an assistant with a Commercial Driver's License, will stop at specific locations on a pre-determined schedule and will see a combination of scheduled and same-day appointments. The locations for service may include public schools, shopping malls, public libraries, and banks, and the vans will be in operation four days a week.

The MHCs deployed by the CCC can serve as a medical home for patients without one and can refer patients with healthcare needs that require more resource-rich care to another appropriate CCC facility. A 2012 report developed for John Muir/Mt. Diablo Community Health Fund and the East and Central County Health Access Action Team in Contra Costa County, California, found that 40 to 80% of patients treated the mobile clinic as their medical home (http://www.johnmuirhealth.com/content/dam/jmh/ Documents/Community/Mobile_Health_Clinics-Increasing_Access_to_Care.pdf) The CCC expects that patients with multiple chronic conditions, previously isolated from regular care sources by their geographic location, will improve the management of their conditions by having regular access to MHCs.

Of the 50,000 patients within the CCC, an estimated 18,000 have multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes. This Mobile Health Clinics project will increase access to care for these sickest patients closer to their homes, so that their conditions do not worsen to the point of needing hospitalization.

Project Goals

By DY5, the Project will:

- Deploy three mobile health clinics to underserved areas and populations of Travis County.
- Offer 576 new clinic days per year in DY5
- Offer approximately 4,800 annual visits by DY5
- Improve patient satisfaction
- Improve management of chronic conditions

How the Project is Related to RHP Goals

This project is related to the following RHP 7 Goals:

3. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
4. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Challenges or Issues Faced by the Performing Provider

Mobile units require a fair amount of in-place infrastructure, which include: wastewater processing; restroom facilities; a waiting area; charging stations; internet access for electronic health records. Despite limited infrastructure in most targeted locations, sites will need to be identified that will allow the MHCs to provide services on an

ongoing basis. Patients will need to be informed of the new services through appropriate channels, and made aware of the MHCs' schedules. Finally, recruiting providers and support staff, particularly those willing to work in a mobile clinic environment, may be a challenge.

How the Project Addresses those Challenges

The CCC will utilize its existing relationships with safety net providers, social service organizations, and city and county agencies to identify and secure appropriate sites for MHCs. To encourage patients to take advantage of available appointments through MHCs, the CCC will advertise MHC locations and schedules through flyers in existing clinic lobbies and waiting rooms as well as through local emergency departments, as well as in those areas where clinics will be deployed. Category 1 improvement milestones assume that MHCs will operate at approximately 50% capacity initially as the CCC continues to establish awareness within the community.

In order to ensure appropriate staffing, the CCC will offer financial or other incentives as needed to recruit qualified providers and support staff to work in a mobile clinic environment. To minimize staffing future costs, existing medical assistants may be cross-trained to receive a Commercial Driver's License.

5-Year Expected Outcome for Providers and Patients

Through the use of mobile health clinics, the CCC expects to provide approximately 1,300 visits in DY3, 3,300 visits in DY4, and 4,800 annual visits in DY5. By DY5, this project will serve approximately 1,600 patients per year. This project aims to increase access to timely care, improve patient satisfaction, and improve management of chronic conditions.

Starting Point/Baseline

Baseline Data: Within Travis County, existing mobile health clinics provide pediatric and dental health services. However, there are no mobile clinics offering services to the CCC patient population at this time.

Time Period for Baseline: 2012

Rationale

Reason for Selection of Project Options and Components

A 2011 analysis developed for Central Health evaluated demographic characteristics to identify geographic areas of need throughout Travis County. Families living below 100% of the Federal Poverty Level are concentrated primarily in the East, Southeast, and Central areas of Travis County.

While poverty is relatively sparse in the western half of Travis County, the far Northwest area also demonstrates high levels of need. This geographically isolated area is designated as a Primary Care Health Professional Shortage Area (HPSA) by the Department of Health and Human Services Health Resources and Services Administration. West and Northwest Travis County also include the greatest concentration of seniors ages 65 and older, who often have barriers to transportation.

In addition to current concentrations of need, data from Nielsen (formerly Claritas) evaluate historical population patterns as well as housing costs and construction trends to project future geographic shifts. Rising property values

in Central Austin are forcing lower income families to relocate to the suburbs and more rural areas, with growth primarily in the East, Southeast, and Northeast parts of the county.

Development in these outlying areas is less densely populated than within the traditional urban core. A lack of transportation and other infrastructure presents challenges for adequate access to healthcare services, yet expected patient volumes are typically too low to support a standalone clinic.

A subsequent 2012 analysis developed for Central Health evaluated uninsured and underinsured patients in Travis County who accessed services at local hospitals but had no recorded visits at community-based outpatient clinics. This analysis identified several pockets of need that were isolated from current healthcare safety net clinics, including:

- East and Southeast Travis County - Austin Colony and River Timber areas
- South Central Travis County - Manchaca area
- Southwest and Northwest Travis County - Greater Hudson Bend area
- Northwest Travis County - Anderson Mill and Fulkes Lane areas
- Northeast Travis County – East Pflugerville area

Transportation barriers also exist for patients who live in the urban core. As detailed in the Austin/Travis County 2012 Community Health Assessment, which drew heavily from focus groups and resident surveys, transportation challenges, especially for low-income residents, mean limited access to healthcare services. (http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/cha_report_8-24-12.pdf, p. vii)

Reason for Selection of Milestones & Metrics

DY2 reflects project planning (P-X) for implementation of a MHC program, including identification of potential locations that can accommodate mobile vans. In order to increase primary care capacity, DYs 3 and 4 include process milestones P-3 and P-5 to establish new MHCs and hire appropriate staff. Improvement milestones in DYs 3 through 5 will demonstrate improved access to primary care, including increased primary care visits and unique patients (I-12).

Unique Community Need Identification Number

- CN.1 - Inadequate access to primary care
- CN.5 – Transportation access for people in the rural areas and also for low-income populations in urban areas
- CN.8 – High rates on non-emergent emergency room department usage and potentially preventable inpatient admissions.

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

This is a new initiative for the CCC.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

- IT-1.7 Controlling High Blood Pressure
- IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression
- IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)

Reasons/Rationale for Selecting the Outcome Measure(s)

As indicated above, low-income residents in Travis County are increasingly located in suburbs and other rural areas with limited access to transportation and other infrastructure. Transportation challenges, especially for low-income residents, also limit access to healthcare services within the urban core.

According to a recent Community Health Assessment completed for Travis County, heart disease is one of the leading causes of death for Travis County residents. Diabetes is the 7th leading cause of death in Travis County according to the same study. The need for mental health services was also the foremost community health concern raised by residents. All of these conditions contribute to potentially preventable hospitalizations. Within the CCC, these three chronic diseases are among those conditions to be aggressively targeted for improved health outcomes; hence the choice of these three outcomes for Mobile Health Clinic patients.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's fourteen projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Expanded Primary Care Capacity via Mobile Health Clinics are outlined below.

While other projects will expand services in community-based outpatient settings, the MHC project will reach beyond the brick and mortar model to extend services to geographically underserved patients in more rural areas of the county and to those with transportation barriers to accessing care. Coordination with providers throughout the CCC will be essential to accommodate patients who require services beyond the scope of the MHC.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.4 : Expansion of Dental Services
- 307459301.1.5: Expanded Specialty Care at Community-Based Outpatient Settings: Musculoskeletal
- 307459301.1.6: Expanded Specialty Care at Community-Based Outpatient Settings: GI
- 307459301.1.7: Expanded Specialty Care at Community-Based Outpatient Settings: Pulmonology
- 307459301.1.8: Telepsych in Federally Qualified Primary Health Clinics

List of Related Category 4 Projects

RD-1: Potentially Preventable Admissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Central Texas Medical Center is proposing expanded primary care hours and capacity for uninsured and underinsured residents in Hays County (Project ID 121789503.1.1). In addition, this project offers a similar intervention to other mobile projects, laying the groundwork for a potential learning collaborative. These projects include ATCIC's Mobile Crisis Outreach Team (133542405.2.2), Hill Country MHDD's Hays County Mental Health Center Mobile Clinic (133340307.1.1), and the University Medical Center at Brackenridge Women's Oncology Care Screening (137265806.2.2).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health as RHP 7's anchor, will foster the development of topical learning collaborative; e.g. smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development Metric 1 [P-X] Develop a plan for implementation of a mobile health clinic program, including identification of potential locations Data Source: Planning documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,220,310	**Milestone 2** [P-3]: Implement/expand a mobile health clinic program Metric 1 [P-3.1]: Number of additional clinics or expanded hours or space Baseline: 0 Mobile Health Clinics Goal: 2 Mobile Health Clinic operational by end of year Data Source: Clinic schedule Milestone 2 Estimated Incentive: $375,698 **Milestone 3** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of	**Milestone 5** [P-3]: Implement/expand a mobile health clinic program Metric 1 [P-3.1]: Number of additional clinics or expanded hours or space Baseline: 2 Mobile Health Clinics Goal: 3 Mobile Health Clinic operational by end of year Data Source: Clinic schedule Milestone 5 Estimated Incentive: $367,223 **Milestone 6** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of	**Milestone 8** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 visits in 2012 Goal: 4,800 visits in DY5 Data Source: Clinic Encounter Data Metric 2 [I-12.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period. Baseline: 0 patients in 2012

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	increased number of providers and staff Baseline: 0 Mobile Health Clinic Staff Goal: 2 physicians, 2 nurses, and 2 clinical assistants Data Source: Clinic Documentation Milestone 3 Estimated Incentive Payment: $375,697 **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.		increased number of providers and staff Baseline: 0 Mobile Health Clinic Staff Goal: 3 physicians, 3 nurses, and 3 clinical assistants (increase of 1 physician, 1 nurse, and 1 clinical assistant over DY3) Data Source: Clinic Documentation Milestone 6 Estimated Incentive Payment: $367,223	Goal: 1,600 patients in DY5 Data Source: Clinic Encounter Data Milestone 8 Estimated Incentive Payment: $ 889,809

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Baseline: 0 visits in 2012 Goal: 1,300 visits in DY3 Data Source: Clinic Encounter Data Milestone 4 Estimated Incentive Payment: $375,697		**Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 visits in 2012 Goal: 3,300 visits in DY4	

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
			Data Source: Clinic Encounter Data Metric 2 [I-12.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period. Baseline: 0 patients in 2012 Goal: 1,100 patients in DY4 Data Source: Clinic Encounter Data Milestone 7 Estimated Incentive	

307459301.1.3	***1.1.3***	***N/A***	***EXPAND PRIMARY CARE CAPACITY VIA MOBILE HEALTH CLINICS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.27* *307459301.3.28* *307459301.3.29*	*IT-1.7* *IT-1.8* *IT-1.0*	*IT-1.7 Controlling High Blood Pressure* *IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression* *IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
			Payment: $367,222	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 1,220,310	Year 3 Estimated Milestone Bundle Amount: $ 1,127,092		Year 4 Estimated Milestone Bundle Amount: $ 1,101,668	Year 5 Estimated Milestone Bundle Amount: $ 889,809
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: **$ 4,338,879**				

Performing Provider: Community Care Collaborative

Project Name: Expansion of Dental Services

Project Identifier: 307459301.1.4 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will expand dental care access for uninsured and underinsured Travis County residents. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project will extend clinic hours and add dentists, hygienists, and support staff to provide dental care in community-based outpatient clinics. In particular, this project will be targeted at providing dental care to underserved pregnant women and patients with multiple chronic medical conditions.

Need for the project: Dental encounters at safety net clinics currently exceed the number of appointment slots available. An analysis of Emergency Department (ED) visits for local hospitals found that more than a third of dental diagnoses treaded in EDs (such as dental caries, chronic periodontitis, chronic gingivitis, and teething syndrome) could be appropriately cared for in a primary dental care setting.

The American Academy of Pediatric Dentistry (AAPD) recognizes that oral health plays a crucial role in the health of both pregnant women and their newborn children. In addition, AAPD cites previous studies which suggest a link between periodontal disease and chronic medical conditions including cardiovascular disease and diabetes.

Target population: The CCC will cover approximately 50,000 patients at or below 200% of FPL; the majority of these patients are uninsured or on Medicaid. This project will work to expand dental care for these patients, in particular for persons with chronic conditions as well as pregnant women.

Category 1 or 2 expected patient benefits: Through expanded access to dental care, the CCC expects an increase of approximately 3,500 dental visits in DY3, 9,000 dental visits in DY4, and 12,000 dental visits in DY5. By DY5, this project will serve more than 4,500 patients annually, with a portion of this increased capacity prioritized for pregnant women and patients with multiple chronic medical conditions.

Category 3 outcomes: 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. Baseline rates and percentage improvement target will be set in DY2 and DY3.

Title of Project: Expansion of Dental Services

Category / Project Area / Project Option: 1.8.6 The expansion of existing dental clinics, the establishment of additional clinics, or the expansion of dental clinic hours

RHP Project Identification Number: 307459301.1.4 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will expand dental care access for uninsured and underinsured Travis County residents. These patients will benefit from increased access as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals

- Pregnancy Prevention
- Community Paramedic Navigator Project

This project will expand access to dental care by extending clinic hours and contracting with and/or hiring additional dentists, hygienists, and support staff to provide dental care in existing community-based outpatient clinics. In particular, this project will be targeted at providing dental care to underserved pregnant women and patients with multiple chronic medical conditions.

Project Goals

- Expand hours and staffing to increase the availability of dental care;
- Increase number of pregnant women receiving perinatal dental care;
- Increase number of patients with chronic medical conditions receiving dental care;
- Improve dental and overall health outcomes;
- Reduce unnecessary dental ED visits;
- Improve patient satisfaction.

How the Project is Related to RHP Goals

This project supports the following RHP Region 7 goals:

- Goal 1 - Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
- Goal 2 - Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Challenges or Issues Faced by the Performing Provider

Recruiting dental providers and support staff, including staff willing to work evenings and/or weekends, may be a challenge. In order to ensure improved access for pregnant women and patients with multiple chronic medical conditions, both patients and providers must be aware of new appointment availability, and patients within these targeted populations should be prioritized for future scheduling. Finally, dental patients historically served by clinics within the CCC provider network have required a high level of restorative care, minimizing the resources available to focus on preventive care.

How the Project Addresses those Challenges

In order to ensure appropriate staffing, the CCC will offer financial or other incentives as needed to recruit qualified providers and support staff to expand dental access. The CCC will inform providers throughout its network of new dental appointment availability and will coordinate patient referrals to prioritize access for pregnant women and patients with multiple chronic medical conditions. Patient navigation and chronic care management provided through the CCC, as well as navigation projects proposed by other Performing Providers in RHP 7, will also help connect appropriate patients to the expanded dental care access available through this project.

With increased dental capacity, the CCC aims to shift its emphasis to preventive dental care. As early diagnosis and treatment lead to improved dental outcomes, this will help break the cycle of acute exacerbations which require urgent dental care and will free additional staff and facility capacity to provide preventive care to a greater number of patients.

5-Year Expected Outcome for Providers and Patients: This project will expand hours and staffing to increase the availability of dental care, with two primary target populations: pregnant women and patients with multiple chronic medical conditions. Through expanded access to dental care, the CCC expects an increase of approximately 3,500 dental visits in DY3, 9,000 dental visits in DY4, and 12,000 dental visits in DY5. By DY5, this project will serve more than 4,500 patients annually. Approximately 75% of increased dental capacity will be prioritized for pregnant women and patients with multiple chronic medical conditions.

Starting Point/Baseline

Baseline Data: Within the CCC, CommUnityCare operates the largest network of Federally Qualified Health Centers in Travis County. In Fiscal Year 2012 (October 2011 – September 2012), CommUnityCare provided approximately 36,000 primary care dental visits through 15 dentists. Existing clinics do not provide any access to after-hours dental care.

During DY2, the CCC will establish a more comprehensive baseline of dental visits and patients served across all providers, including visits for pregnant women and patients with multiple chronic conditions.

Rationale

Reason for Selection of Project Options and Components

Dental health is a key component of overall health. A 2008 report commissioned by the Texas Dental Association found that untreated dental disease not only affects the mouth but can have physical, mental, economic, and social consequences (*Building Better Oral Health: A Dental Home for All Texans* - http://www.buildingbetteroralhealth.org/media/TDA_full_report.pdf). Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing oral health services will improve health outcomes. In particular, this project will be targeted at improving dental access for underserved pregnant women and patients with chronic medical conditions.

Building Better Oral Health: A Dental Home for All Texans recommends finding dental homes for priority populations, including pregnant women on Medicaid. The American Academy of Pediatric Dentistry (AAPD) also recognizes that oral health plays a crucial role in the health of both pregnant women and their newborn children. Research suggests a link between periodontal disease and adverse outcomes in pregnancy, including preterm deliveries, low birth weight babies, and preeclampsia. Furthermore, mothers are at risk of infecting their newborn children with cariogenic bacteria that increases the risk of early childhood caries. The AAPD recommends that pregnant woman have an oral evaluation, be counseled on proper oral hygiene, and be referred for preventive and therapeutic oral health care as appropriate (http://www.aapd.org/media/Policies_Guidelines/G_PerinatalOralHealthCare.pdf).

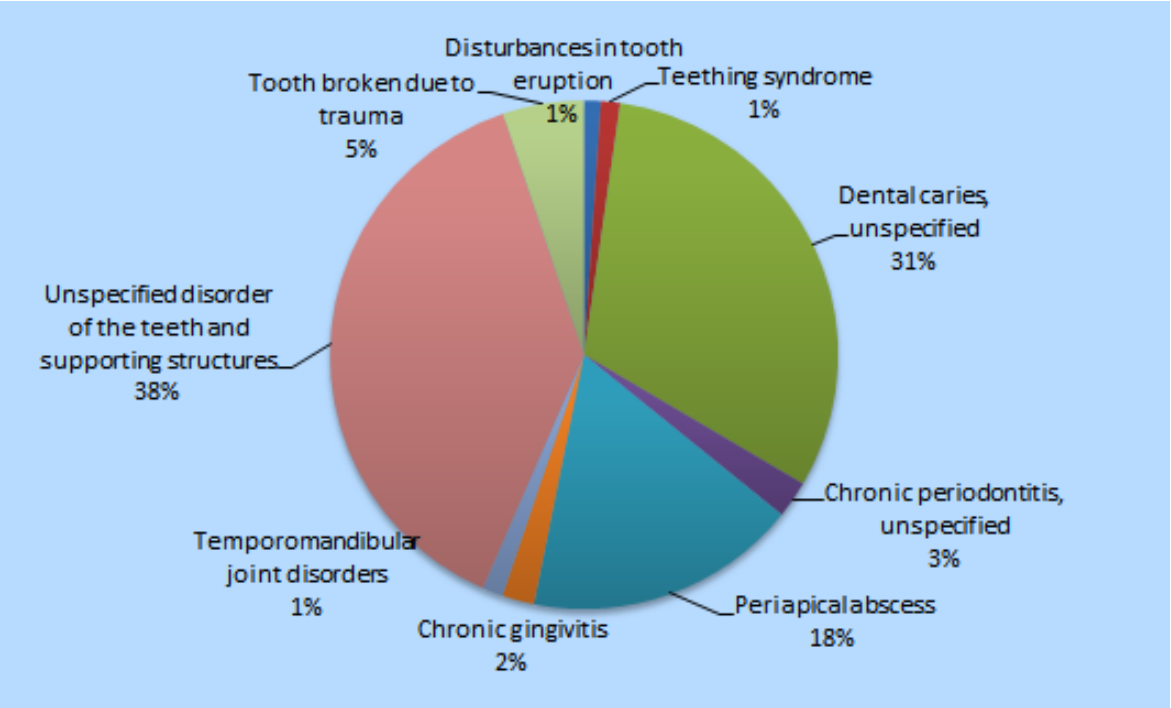
AAPD also cites previous studies which suggest a link between periodontal disease and chronic medical conditions including cardiovascular disease and diabetes (http://www.perio.org/newsroom/archive-overall-health). Researchers from the National Institute of Diabetes and Kidney Disease found that diabetic patients with severe gum disease were more than three times more likely to die of combined kidney and heart dysfunction compared with other groups with no or mild-to-moderate gum disease, even after adjusting for other risk factors, such as high blood pressure and tobacco use (http://www.buildingbetteroralhealth.org/media/TDA_full_report.pdf). Among

Travis County residents, a 2011 analysis found that more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition. Within the CCC, an estimated 18,000 patients have multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes. Providing dental care for these patients will be integral to the CCC's emphasis on whole health, prevention, and wellness.

Low-income Travis County residents have limited options when seeking dental care. In all of Travis County, seven clinics serve low-income patients; four of these are operated by an FQ, one serves HIV patients only, another relies on volunteers, and the seventh is a student-staffed clinic operated by the hygienist program at Austin Community College. With a limited supply of appointments, new patients often wait months to be seen; emergency appointments are either first come, first serve or already scheduled weeks in advance. As a result, many patients seek relief in the ED.

An analysis of ED visits for hospitals reporting data to the Integrated Care Collaboration revealed approximately 9,000 dental diagnosis codes. Of these, more than a third represents diagnoses (such as dental caries, chronic periodontitis, chronic gingivitis, and teething syndrome) that could be appropriately treated in a primary dental care setting, potentially eliminating unnecessary ED visits (Exhibit 1.)

Exhibit 1 – Distribution of Dental Diagnoses for Uninsured and Underinsured Patients at Local EDs



Source: Analysis of approximately 9,000 dental diagnosis codes provided in the Emergency Department by hospitals reporting data to the ICC, 5/26/10-5/25/11

Reason for Selection of Milestones & Metrics

DY2 includes P-X to reflect project planning, including a needs analysis and the establishment of baseline data to inform the expansion of dental services. In order to increase dental care capacity, DY3 includes

process milestones P-4, P-5, and P-6 to increase utilization of available dental clinic space, increase clinic hours, and implement programs to increase dental services to improve maternal oral health.

Improvement milestones in DYs 3 through 5 will demonstrate improved access to dental care through increases in the number of pregnant women who have seen a dental provider within the past 12 months (I-14). In order to demonstrate improved access to dental care for patients with chronic medical conditions, this project uses customized milestone I-X. This milestone follows to format of I-14 and is adjusted for the target population of patients with chronic medical conditions who have seen a dental provider within the past 12 months. Finally, the CCC will document lessons learned in order to develop new methodologies or refine existing ones, through P-X.

Unique Community Need Identification Number

- CN.3 – Inadequate access to dental care
- CN.9 – High rates of chronic disease
- CN.12 – Lack of adequate prenatal care

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative: This project builds upon local provider efforts to expand access to dental care for low-income adult populations. The push to extend care capacity specifically for those with chronic conditions and pregnant women represents a new focus for the delivery of dental care.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-7 Oral Health Outcomes:

- IT-7.8: Chronic Disease Patients Accessing Dental Services : Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

Reasons/Rationale for Selecting the Outcome Measure(s)

Providing dental care for patients with chronic conditions is integral to the CCC's emphasis on whole health, prevention, and wellness. Patients are more likely to seek dental services when given a formal referral, and the CCC will coordinate referrals from medical providers and provide patient navigation to ensure that patients with chronic conditions receive priority for dental appointments. Through expanded access to care and improved referral tracking, the CCC will increase the number of patients with multiple chronic medical conditions receiving dental care and improve dental and overall health outcomes.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's fourteen projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Expansion of Dental Services are outlined below.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.3: Mobile Primary Care
- 307459301.1.5: Expanded Specialty Care at Community-Based Outpatient Settings: Musculoskeletal
- 307459301.1.6: Expanded Specialty Care at Community-Based Outpatient Settings: GI
- 307459301.1.7: Expanded Specialty Care at Community-Based Outpatient Settings: Pulmonology
- 307459301.2.6: Community Paramedic Patient Navigation Program
- 307459301.2.2: Expand Chronic Care Management Models
- 307459301.2.3: Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients

List of Related Category 4 Projects

RD-1: Potentially Preventable Admissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

With its focus on pregnant mothers, this project will support University Medical Center Brackenridge's Obstetrics Navigation Project (137265806.2.1) and the City of Austin Health & Human Services Department's Prenatal & Post-natal Improvement Program (201320302.2.4). With its aim to improve management of chronic conditions, this project also has a similar target population to University Medical Center Brackenridge's Chronic Care Management for Adults (137265806.2.6) and ATCIC's project to Integrate Primary and Behavioral Health Care Services (133542405.2.1).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health as RHP 7's anchor, will foster the development of topical learning collaborative; e.g. smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This

multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

In addition, the CCC will participate in the existing Central Texas Dental Collaborative, which includes organizations that provide dental services to underserved populations in Travis, Williamson, Bastrop, Caldwell, and Hays Counties. The CCC will identify lessons learned, particularly related to providing dental care to pregnant women and patients with chronic conditions. By reviewing project data and sharing challenges and solutions, CTDC participants may expand services to additional target populations as appropriate.

Project Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.4	***1.8.6***	***1.8.6***	***EXPANSION OF DENTAL SERVICES***
Community Care Collaborative			*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.4*	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Conduct a needs/gap analysis, in order to inform the establishment or expansion of services/programs Metric 1 [P-X]: Documentation of gap assessment Goal: Conduct gap assessment Data Source: Planning documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,813,892 **Milestone 2** [P-X]: Establish a baseline, in order to measure improvement over self Metric 1 [P-X]: Establish comprehensive baseline of dental care visits and patients served, including visits for pregnant women and patients with chronic medical conditions.	**Milestone 3** [P-4]: Establish additional / expand existing / relocate dental care clinics or space Metric 1 [P-4.1]: Documentation of expansion or efficient use of existing space Goal: Establish dental care at one additional clinic Data Source: Construction Documents / Clinic documentation Milestone 3 Estimated Incentive Payment: $ 670,133 **Milestone 4** [P-5]: Expand the hours of a dental care clinic or office, including both evening and/or weekend hours Metric 1 [P-5.1]: Increased number of hours of a dental care clinic or office over baseline,	**Milestone 8** [I-14]: Increase number of special population members that access dental services Metric 1 [I-14.1]: Increase the number of *pregnant women* that have been seen by a dental provider within the past 12 months Baseline: TBD Goal: Increase of 340 *pregnant women* that have been seen by a dental provider within the past 12 months, compared to baseline Data Source: Encounter data Milestone 8 Estimated Incentive Payment: $ 1,091,694 **Milestone 9** [I-X]: Increase number of special population members that access dental services Metric 1 [I-X]: Increase the number of patients with *chronic medical conditions*	**Milestone 11** [I-14]: Increase number of special population members that access dental services Metric 1 [I-14.1]: Increase the number of *pregnant women* that have been seen by a dental provider within the past 12 months Baseline: TBD Goal: Increase of 450 *pregnant women* that have been seen by a dental provider within the past 12 months, compared to baseline Data Source: Encounter data Milestone 11 Estimated Incentive Payment: $ 881,753 **Milestone 12** [I-X]: Increase number of special population members that access dental services Metric 1 [I-X]: Increase the number of patients with *chronic medical conditions*

307459301.1.4	***1.8.6***	***1.8.6***	***EXPANSION OF DENTAL SERVICES***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.4*	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Goal: Establish baseline Data Source: Clinic Encounter Data Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 1,813,891	number of patients served during extended hours Baseline: 40 hours/week Goal: 46 hours/week at a minimum of 1 location Data Source: Clinic Schedule Milestone 4 Estimated Incentive Payment: $ 670,132 **Milestone 5** [P-6]: Implement / expand alternative dental care delivery systems to underserved populations <u>Metric 1</u> [P-6.4]: Implement program to increase dental services to improve maternal oral health Documentation of implementation Data Source: Clinic Documentation Milestone 5 Estimated Incentive		that have been seen by a dental provider within the past 12 months Baseline: TBD Goal: Increase of 2,200 patients with *chronic medical conditions* that have been seen by a dental provider within the past 12 months, compared to baseline Data Source: Encounter data Milestone 9 Estimated Incentive Payment: $ 1,091,694 **Milestone 10** [P-X]: Develop a new methodology, or refine an existing one, based on learnings	that have been seen by a dental provider within the past 12 months Baseline: TBD Goal: Increase of 3,050 patients with *chronic medical conditions* that have been seen by a dental provider within the past 12 months, compared to baseline Data Source: Encounter data Milestone 12 Estimated Incentive Payment: $ 881,753 **Milestone 13** [P-X]: Develop a new methodology, or refine an existing one, based on learnings

307459301.1.4	***1.8.6***	***1.8.6***	***EXPANSION OF DENTAL SERVICES***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.4*	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Payment: $ 670,132 **Milestone 6** [I-14]: Increase number of special population members that access dental services Metric 1 [I-14.1]: Increase the number of *pregnant women* that have been seen by a dental provider within the past 12 months Baseline: TBD Goal: Increase of 100 *pregnant women* that have been seen by a dental provider within the past 12 months, compared to baseline Data Source: Encounter data Milestone 6 Estimated Incentive Payment: $ 670,132 **Milestone 7** [I-X]: Increase number of special population members that access		Metric 1 [P-X]: Document lessons learned and how applied to new or existing methodologies Data Source: Clinic Documentation Milestone 10 Estimated Incentive Payment: $ 1,091,694	Metric 1 [P-X]: Document lessons learned and how applied to new or existing methodologies Data Source: Clinic Documentation Milestone 13 Estimated Incentive Payment: $ 881,752

307459301.1.4	***1.8.6***	***1.8.6***	***EXPANSION OF DENTAL SERVICES***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.4*	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	dental services <u>Metric 1</u> [I-X]: Increase the number of patients with *chronic medical conditions* that have been seen by a dental provider within the past 12 months Baseline: TBD Goal: Increase of 750 patients with *chronic medical conditions* that have been seen by a dental provider within the past 12 months, compared to baseline Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $ 670,132			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 3,627,783	Year 3 Estimated Milestone Bundle Amount: $ 3,350,661		Year 4 Estimated Milestone Bundle Amount: $ 3,275,082	Year 5 Estimated Milestone Bundle Amount: $ 2,645,258
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 12,898,784				

Performing Provider: Community Care Collaborative
Project Name: Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions
Project Identifier: 307459301.1.5 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): This project will expand access to non-surgical musculoskeletal specialty services for uninsured, underinsured, Medicaid, and Medicare patients by contracting with and/or hiring a variety of musculoskeletal providers, including sports medicine specialists, podiatrists, physical medicine and rehabilitation specialists, and support staff to serve as part of the CCC's provider network. The project will also support the development of a new specialty clinic that will include a facility able to accept physical therapy referrals from specialists serving the target population.

Need for the project: Currently, low income, uninsured, or publicly insured people in Travis County have few options available to address musculoskeletal issues other than orthopedic surgeons practicing at the University Medical Center Brackenridge (UMCB) Specialty Clinic, a clinic based at the region's safety-net hospital in downtown Austin. Wait times for orthopedic referrals average more than six months. Podiatry services are available at the UMCB clinic for this population, although wait times for this service average as high as eight months. Currently, physical therapy services are extremely limited for the target population.

Target population: The CCC will initially cover 50,000 patients at or below 200% of poverty. This project will serve approximately 1,800 people who have musculoskeletal issues that can be addressed without surgery.

Category 1 or 2 expected patient benefits: The project will provide an additional 1,800 people with access to musculoskeletal specialty care services. Community-based settings where musculoskeletal specialists will provide care serve a high percentage of Medicaid patients, including the new multispecialty clinic that will be developed to offer physical therapy services patients being served in the safety net. Thus, a large portion of the benefit of the additional providers and facilities will extend to the Medicaid population as well.

Category 3 outcomes: The CCC expects that the project will result in improved quality of life for the patient population (IT-10.1 Quality of Life), wait times for orthopedic surgery consultations will reduce (IT-1.1 Third Next Available Appointment), and achieve improved functional status as a result of physical therapies (IT-10.7 Other Outcome Improvement Target).

Title of Project: **Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions**

Category / Project Area / Project Option: **1.9.2: Improve Access to Specialty Care**

RHP Project Identification Number: **307459301.1.5 Pass 3**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

This project will expand access to non-surgical musculoskeletal specialty services for uninsured, underinsured, Medicaid, and Medicare patients by contracting with and/or hiring physicians with specialty or sub-specialty training in sports medicine and/or physiatry who, aided by ancillary physical therapy services at the new Southeast Health and Wellness Center, can provide a full range of rehabilitation services for patients who do not require orthopedic surgery, such as those with obesity or diabetes-related mobility issues or job injuries, to serve as part of the CCC's provider network. The project will also support the development of a new specialty clinic where care will be provided and include a facility to accept physical therapy referrals from specialists serving the target population.

These patients will benefit from musculoskeletal services as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics

- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project

Currently, low income, uninsured, Medicaid, or Medicare beneficiaries in Travis County have few options available to address musculoskeletal issues other than orthopedic surgeons practicing at the University Medical Center Brackenridge (UMCB) Specialty Clinic, a clinic based at the region's safety-net hospital in downtown Austin. Wait times for orthopedic referrals average more than six months. Orthopedists at the UMCB Specialty Clinic estimate that many of the patients they see do not need surgery. Podiatry services are available at the UMCB clinic for this population, although wait times for this service average as high as eight months. Currently, physical therapy services are extremely limited for the target population.

People who are obese or are diagnosed with diabetes often have problems with mobility. Studies have shown that there is a statistically significant positive relationship between the probability of having a musculoskeletal disorder and the level of obesity. People with diabetes have an increased risk of chronic foot and other musculoskeletal disorders related to nerve damage caused by the disease. In Region 7 and in Travis County, rates of obesity are rising, according to the Centers for Disease Control and Prevention (CDC). According to a recent analysis conducted by the Austin/Travis County Health and Human Services Department, Travis County experienced a greater increase in diabetes prevalence between 2007 and 2010 than the state overall. Both obesity and diabetes are conditions that can impact mobility and can hinder a patient's ability to successfully complete life tasks such as working or caring for children.

Central Texas is also host to a growing number of service related industries such as retail, education, food service, and accommodation, according to a recent economic analysis of regional counties, including Travis County. Many of these industries typically employ low-wage workers and do not provide health coverage for their employees. These industries frequently require employees to work on their feet most of the day. Injuries for people working in these fields that are not immediately addressed can impede the ability to work.

People with obesity, diabetes, minor injuries, and other conditions that hinder physical mobility can benefit from a variety of non-surgical services such as podiatry, kinesiology, sports medicine, and physical therapy. For instance, podiatrists can help clean infected toes for diabetics. Physical therapists can help obese people begin an effective exercise regimen. Sports medicine providers can help people manage the healing process from injuries and provide services like cortisone shots that help people get back to work. All of these services can significantly improve patients' quality of life without resorting to unnecessary surgery.

This project aims to expand the capacity and range of services to treat musculoskeletal issues by hiring or contracting with additional providers trained to address these issues in community-based settings in order to serve approximately 1,800 patients with musculoskeletal issues that can be addressed without surgery. Providers will rotate among community-based medical homes that currently serve the target population. The project will also support the development of an additional multispecialty clinic located in southeast Austin, Southeast Travis County has consistently been identified as an area with high levels of poverty and limited healthcare infrastructure. Approximately 270,000 people reside within a 5-mile radius of the proposed Southeast Health and Wellness Center, and 46% live below 200% of the Federal Poverty Level. This new specialty clinic will provide space for musculoskeletal specialists to practice and include a physical therapy facility, to be staffed by one physical therapist and support staff, to which providers may refer patients who need that service.

CCC providers will engage in continuous quality improvement that is evaluated on a quarterly basis. CCC staff will be dedicated to monitoring provider performance across the CCC provider network. Performance data will be presented at quarterly planning sessions where providers will be able to share best practices and improve their patient care strategies. Aggregate patient outcomes for these diagnoses will also be monitored and trends will be discussed and acted upon.

Project Goals

- Improve low income patients' quality of life by providing timely musculoskeletal services in the most appropriate setting
- Reduce wait times for orthopedic surgery consultations by reserving these appointments for patients who truly need surgery
- Improve patients' functional status.
- Expand the number of specialty care facilities offering specialty care and physical therapy services to the target population by providing these services at a newly renovated clinic in Southeast Austin.
- Establish best practices among safety net providers to provide musculoskeletal care to the target population.

Challenges or Issues Faced by the Performing Provider

The performing provider anticipates that provider recruitment in this specialty will be a challenge. Safety net providers frequently struggle to recruit providers to serve their populations because the populations are perceived as challenging in that they may suffer from multiple chronic health conditions. There may also be a challenge in encouraging patients and providers alike to accept a new practice in treating musculoskeletal conditions.

How the Project Addresses those Challenges

To address the provider recruitment challenge, the CCC will make aggressive efforts to outreach to residency programs that train physicians and other providers to provide these services. We will pay providers at competitive salaries, and, where possible, incorporate their services into local Federally Qualified Health Centers so the providers can enjoy the benefit of Federal Tort Claims Act (FTCA) coverage. At the same time, the University of Texas Southwestern Medical Center, which operates a physical medicine and rehabilitation residency program at UMCB, will be a natural partner in finding providers to serve this population. The CCC as a whole will incorporate musculoskeletal care into standard practices to ensure that cultural change will be achieved to accept new treatment modalities.

How the Project is Related to RHP Goals

This project primarily meets the following two goals of Region 7.

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. Adding new providers, a new service line, and a new specialty care facility will significantly enhance the healthcare infrastructure available to meet an unmet need of low-income, uninsured, and publicly insured populations in Travis County.

2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. By providing musculoskeletal therapies in the outpatient setting, rather than limiting care offerings to surgical consultations, patients and families will be able to access less

invasive, less costly care that suits the treatment of their condition. Over time, this additional access will reduce health system costs by treating conditions before they become more severe, and by providing care options other than surgery.

3. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. Providing a broader range of musculoskeletal services that address patients' issues in a timely way will improve their experience of care as wait times for care decrease and health outcomes improve.

Five Year Expected Outcome

By the end of the demonstration period, two additional musculoskeletal providers will be available to the target population, 1,800 patients will be served, and quality of life for these patients living with pain and/or mobility issues will improve. At the same time, wait times for orthopedic consultations will decrease as patient volume shifts to a more appropriate level of care. Patients are also expected to have measurably improved functional status as a result of having access to non-surgical musculoskeletal therapies.

Starting Point/Baseline

Baseline Data

0 – These services are not currently provided to the CCC population.

Time Period for Baseline

N/A

Rationale

Reason for Selection of Project Options and Components

Travis County residents who are low-income, uninsured or have public insurance coverage such as Medicaid, CHIP, or the local Medical Access Program (MAP) struggle with access to specialty care services due to lack of care capacity within the existing provider network serving this population. At the same time, the population in Central Texas is growing, placing an increased burden on the already strained network of specialty care providers dedicated to providing care to underserved populations. Indeed, musculoskeletal specialty services are virtually non-existent to the target population outside of surgical options. Beyond this, physical therapy services are almost completely unavailable to the target population at this time. Project option 1.9.2 – Expand Specialty Care Capacity was chosen.

Option 1.9.2 includes four required components:

a) **Increase services availability with extended hours.** After a series of planning tasks, this project will begin by hiring providers to offer care in community-based, outpatient settings, beginning in DY 3. More providers will allow the number of hours of care to increase an amount to be determined during the DY 2 planning process.
b) **Increase number of specialty clinic locations.** The project will increase the number of specialty clinic locations by rotating newly hired providers among existing community-based outpatient settings that serve the population but do not yet provide this type of service. The project will also develop a portion of a clinic

under renovation in southeast Austin that will serve as a new specialty care site and include capacity to provide physical therapy to the patient population. Care offered at the new location will be in addition to care expanded at existing sites.

c) **Implement transparent, standardized referrals across the system.** Musculoskeletal specialty care will be provided within the context of the newly formed Community Care Collaborative (CCC). The CCC's function will be to monitor and coordinate care for the entire covered population. A robust referral system will be developed that will have standard operations across the entire network of care.
d) **Conduct quality improvement.** Expanded specialty care, especially in musculoskeletal care where a range of services has not been available to the population previously, will require careful planning, monitoring, and revision of expansion plans as providers learn move about providing this service to this population. Providers will conduct continuous quality improvement that will be evaluated quarterly.

Reason for Selection of Milestones & Metrics

Because musculoskeletal services in the outpatient setting is a new service for the patient population, the CCC intends to conduct a number of planning processes in DY 2 to understand the nature of the capacity deficit and plan for the optimal way for these services to be expanded, including which types of providers would be most appropriate to provide care according to the needs of the population. The provider must also determine a baseline for musculoskeletal services provided across the entire target population of the CCC in order to measure improvement targets.

In DY 3, to be launched in DY 4, the provider will complete a planning process to prepare and then work to renovate a new specialty clinic to provide musculoskeletal specialty care services to the target population. The facility will include the capacity to accept physical therapy referrals from musculoskeletal specialists. The multispecialty service site will be tailored to meet the specific care and cultural needs of the patient population.

In DY 3, 4, and 5, the provider will hire providers and provide care to additional patients. These milestones will grow over time as care is expanded at existing clinic sites and at the new site to open in DY 4.

Unique Community Need Identification Number

CN.2 Inadequate access to specialty care.

CN.9 Rising rates of diabetes

CN.11 Rising rates of physical inactivity and obesity

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

Musculoskeletal services are not currently available in community-based settings to the target population. This project will be a new service.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

N/A

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

IT-10.1 Quality of Life

IT-10.7 Other Outcome Improvement Target (Measuring functional status)

IT-1.1 Third Next Available Appointment

Reasons/Rationale for Selecting the Outcome Measure(s)

While many people may be able to live with pain or chronic conditions such as obesity and diabetes as they complete basic life tasks, their quality of life (IT-10.1) is reduced because their conditions prevent them from participating fully in society. By expanding and broadening the spectrum of musculoskeletal services available to this population, the performing provider expects the functioning and quality of life of patients and their families to improve. Additionally, as access to non-surgical musculoskeletal services is increased, the CCC expects that wait times for orthopedic surgeons will decrease, thus the reason for selecting IT-1.1, third next available appointment. Finally, the CCC will evaluate the quality of the non-surgical musculoskeletal care to ensure that functional status among the target population is improving as a result of that care.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This project reinforces other projects proposed by the CCC, including expanded access to primary and specialty care, and the development of standard protocols for the management of chronic diseases in the CCC population.

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.6: Expanded Specialty Care Services at Community-Based Outpatient Settings: Gastroenterology
- 307459301.1.7: Expanded Specialty Care Services at Community-Based Outpatient Settings: Pulmonary
- 307459301.1.3: Mobile Health Clinics
- 307459301.2.2: Chronic Care Management Protocols

List of Related Category 4 Projects *(RHP Project ID Number)*

RD-2 – All-Cause 30-Day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

This project relates to other projects in the RHP that expand primary and specialty care services, including:

176692501.1.1: Expanding Access to Specialty Care

186599001.2.1: Family and Child Obesity

201320302.2.2: Expansion of Community Diabetes Project

137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.5	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY TO TREAT CHRONIC AND ACUTE MUSCULOSKELETAL CONDITIONS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.5* *307459301.3.31* *307459301.3.30*	*IT-10.1* *IT-10.7* *IT-1.1*	*Quality of Life* *Other Outcome Improvement Target* *Third Next Available Appointment*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 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 specialty care gap assessment based on community need. Metric 1 [P-1.1]: Written documentation of gap assessment Baseline/Goal: 0/1 assessment Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,206,027 **Milestone 2** [P-X]: Complete a planning process to evaluate the optimal way to expand musculoskeletal service capacity across the system. Metric 1 [P-X.1]: Written documentation of an musculoskeletal service capacity expansion plan.	**Milestone 4** [P-X]: Complete a planning process to prepare for the expansion of a clinic location. Metric 1 [P-X.1]: Written documentation of the specialty clinic facility plan. Baseline/Goal: 0/1 plan Data Source: Program records Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,113,900 **Milestone 5** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of specialist providers		**Milestone 7** [P-11]: Launch/expand a specialty care clinic. Metric 1 [P-11.1]: Establish/expand a specialty care clinic. Goal: Launch a new specialty care clinic location. Data Source: Documentation of clinic operations. Milestone 7 Estimated Incentive Payment: $1,088,774 **Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number	**Milestone 10** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of specialist providers Baseline: 0 FTE providers Goal: 2.0 FTE providers over baseline Data Source: Human resources records Milestone 10 Estimated Incentive Payment *(maximum amount):* $1,319,092 **Milestone 11** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for

307459301.1.5	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY TO TREAT CHRONIC AND ACUTE MUSCULOSKELETAL CONDITIONS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.5* *307459301.3.31* *307459301.3.30*	*IT-10.1* *IT-10.7* *IT-1.1*	*Quality of Life* *Other Outcome Improvement Target* *Third Next Available Appointment*	
Year 2 **(10/1/2012 – 9/30/2013)**	**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: 0/1 plan Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,206,027 **Milestone 3** [P-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties. Metric 1 [P-3.1]: Establish baseline for performance indicators. Baseline/Goal: No baseline determined/baseline determined Data Source: Clinical encounter data Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,206,027	Baseline: 0 FTE providers Goal: 3.0 FTE providers over baseline (one physician level musculoskeletal specialist, one physical therapist, one support staff) Data Source: Human resources records Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,113,900 **Milestone 6** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits		of specialist providers Baseline: 0 FTE providers Goal: 1.50 FTE providers over baseline Data Source: Human resources records Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,088,774 **Milestone 9** [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 Baseline: 0 visits Goal: 2,286 additional visits over	patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits Baseline: 0 visits Goal: 3,048 additional visits over baseline. Data Source: Clinical encounter data Milestone 12 Estimated Incentive Payment *(maximum amount):* $1,319,092

307459301.1.5	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY TO TREAT CHRONIC AND ACUTE MUSCULOSKELETAL CONDITIONS***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.5* *307459301.3.31* *307459301.3.30*	*IT-10.1* *IT-10.7* *IT-1.1*	*Quality of Life* *Other Outcome Improvement Target* *Third Next Available Appointment*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Baseline: 0 visits Goal: 1,524 additional visits over baseline. Data Source: Clinical encounter data Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,113,900		baseline Data Source: Clinical encounter data Milestone 9 Estimated Incentive Payment *(maximum amount):* $1,088,775	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,618,081	Year 3 Estimated Milestone Bundle Amount: $3,341,700		Year 4 Estimated Milestone Bundle Amount: $3,266,323	Year 5 Estimated Milestone Bundle Amount: $2,638,184
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $12,864,288				

Community Care Collaborative

Expand Specialty Care Capacity for Gastroenterology

307459301.1.6 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): This project will contract with or hire additional gastroenterologists and support staff to practice in community based settings. A new multi-specialty clinic, to be known as the Southeast Health and Wellness Center, in a low-income area of Travis County will also be developed as a new location to provide these services.

Need for the project: People with low-incomes and/or public insurance programs often have to wait four months for a gastroenterology appointment. Wait times for gastroenterology liver services are close to one year. The only clinic option available is located in a hospital in downtown Austin. Among Travis County residents, colon cancer is one of the top two causes of cancer-related deaths. According to analysis of the safety net patient population in Region 7 and surrounding counties, Hepatitis C related visits increased approximately 16% between 2009 and 2010. Data from a recent survey of local safety net providers show that only 34% of needed GI referrals are able to obtain care. Preventive colonoscopies are not available to the target population at this time.

Target population: The target population will be CCC enrollees who need gastroenterology services. All CCC enrollees have incomes under 200% of the Federal Poverty Level and/or have multiple chronic conditions. Over the course of the waiver, this project is expected to serve nearly 1,800 patients. New providers will be located at community based settings that serve a high proportion of Medicaid patients, and all CCC related provides will also serve Medicaid patients as part of their practices.

Category 1 or 2 expected patient benefits: The project seeks to expand the number of gastroenterologists available to serve 1,800 new patients and offer those services in locations that are better connected with patients' medical homes. The project will also support the development of a new multispecialty clinic site in Southeast Travis county, an area consistently identified as very high need.

Category 3 outcomes: The outcomes of this project are to reduce wait times for gastroenterology services, effectively manage the longterm medications of patients with Hepatitis C and ensure these patients are tested and treated for depression, a known side effect of Hepatitis C treatment.
IT-1.1 Third Next Available Appointment
IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression
IT-1.20 Other Outcome Improvement Target – Annual Monitoring for Patients on Persistent Medications – boceprevir or telaprevir in combination with peginterferon alfa and ribavirin (Class 1, Level A)
IT-12.3 Colorectal Cancer Screening (HEDIS 2012)

Title of Project: **Expand Specialty Care Capacity for Gastroenterology**

Category / Project Area / Project Option: **1.9.2 Expand Access to Specialty Care**

RHP Project Identification Number: **307459301.1.6 Pass 3**
Performing Provider Name: **Community Care Collaborative**
Performing Provider TPI: **307459301**

Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

This project will expand access to Gastroenterology (GI) services to 1,800 new patients by contracting with and/or hiring two additional GI physicians and related support staff to serve within the CCC's constellation of community-based care settings. With these providers, the project will seek to reduce wait times for care, expand capacity for colorectal cancer screening, and improve adherence to Hepatitis C drug treatments. CCC patients will benefit from expanded access to gastroenterology services as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Health Paramedic Patient Navigation

GI specialty services for the target population are offered primarily at one hospital-based specialty clinic located at University Medical Center Brackenridge (UMCB) in downtown Austin. A local Federally Qualified Health Center (FQHC) provides a two GI clinic sessions per week at a north Austin site. Even with some GI care available in the

community, wait times for GI appointments at the UMCB specialty clinic remain an average 121 days, or approximately four months. Patients who need to see a GI for liver concerns, including Hepatitis C infection, often have to wait nearly a year for care. Data from a recent survey of local safety net providers show that only 34% of needed GI referrals are able to obtain care.

Long wait times for gastroenterology care are of particular concern given the prevalence of GI related chronic diseases in Region 7 and in Travis County. Among Travis County residents, colon cancer is one of the top two causes of cancer-related deaths. Yet, there are no screening colonoscopies provided for the CCC population, and the existing UMCB facility has no capacity to expand colonoscopy services. This leaves the target population with a significant gap in preventive care designed to address this leading cause of cancer death.

According to projections from the Texas State Data Center, the population in Region 7 grew dramatically between 2000 and 2010. Travis County's population is expected to grow by another 7% during the waiver period. Population growth will place even more demand on already scarce GI resources. Additionally, demand for GI services is expected to increase due to guidelines recently issued by the Centers for Disease Control and Prevention (CDC) that recommend that all people born during 1945-1965 be tested for Hepatitis C. Hepatitis C infection is a growing concern for low-income Travis County residents. According to analysis of the safety net patient population in Region 7 and surrounding counties, Hepatitis C related visits increased approximately 16% between 2009 and 2010.

This project addresses current unmet need and anticipated future needs for GI services by expanding GI services into multiple community based clinics that currently serve the target population. Additional clinic sessions with new GI providers are expected to reduce wait times for care. Expansion into community-based settings is expected to transform the health system by offering specialty services in the context of the patient's medical home, minimizing the need to travel to a separate clinic. Care provided in a familiar location that is likely closer to home is expected to achieve better adherence to appointment schedules and treatment plans.

As part of the community-based care expansion for GI services, a new multispecialty clinic site in southeast Travis County will be developed to provide this care. Southeast Travis County has consistently been identified as an area with high levels of poverty and limited healthcare infrastructure. Approximately 270,000 people reside within a 5-mile radius of the proposed Southeast Health and Wellness Center, and 46% live below 200% of the Federal Poverty Level. In addition to expanding care, this project will evaluate the potential to perform screening colonoscopies at this new care site and contract with local providers to perform screening colonoscopies for CCC patients within their facilities.

Project Goals

- Increase the number of GI providers offering services in community-based settings to low-income, uninsured, and publicly insured patients.
- Develop the Southeast Health and Wellness Center to provide community-based GI care and expand capacity for colorectal cancer screenings
- Decrease the time until third next available appointment to see a GI specialist
- Increase the rate of Hepatitis C patients who successfully adhere to their treatment regimen.

Challenges or Issues Faced by the Performing Provider

Lack of available workforce is a challenge to the implementation of this project because specialty providers are difficult to recruit and retain. Additionally, potential providers must be willing to serve a potentially challenging patient population that will likely suffer from multiple chronic diseases. Integrating specialty care into settings that have traditionally offered primary care may prove to be a challenge at initial implementation. Due to the side effects of the medications, many do not complete the treatment regimen needed to decrease the viral load.

How the Project Addresses those Challenges

The CCC and its membership organizations have existing relationships with area medical schools and residency programs. We will build on these relationships and aim to retain as many of these providers as we can to provide GI services to our low-income populations. The CCC will also work with the UT-Austin school of nursing to ensure an adequate supply of nurses and other medical support staff that can support the work of expanded specialty care services. To manage care coordination and co-location of primary care and specialty care services, the CCC will develop and implement a standard set of care protocols that will manage the care of the entire target population under a uniform set of guidelines. The CCC will build in specific strategies to screen and treat Hepatitis C patients for depression to minimize non-compliance with Hepatitis C treatment drugs.

How the Project is Related to RHP Goals

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. – This project enhances and expands existing specialty care infrastructure to better meet the demand of low-income populations. This infrastructure expansion will allow the target population to access needed preventive screenings and better management of care for GI related chronic conditions.

2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. By expanding opportunities to receive gastroenterology services in a timely manner, patients will be able to have their medical concerns addressed more quickly and before problems escalate to more serious issues. Services offered in community-based medical home settings will allow the patient access to care in a more comfortable, appropriate setting.

Five-Year Expected Outcome

By the end of the demonstration period, two additional gastroenterologists will be available to the target population at community-based locations, 1,800 people will receive GI care, and a new multi-specialty clinic will be available in a high-need area of Travis County. Among the target population, wait times for general GI care and GI liver care are expected to decrease, medication management of hepatitis C patients is expected to improve, and rates of colorectal cancer screening are expected to increase.

Starting Point/Baseline

Between January and December, 2011, people served in the safety net received 1,343 GI visits at the UMCB Specialty Clinic.

Time Period for Baseline:

January-December, 2011

Rationale

Reason for Selection of Project Options and Components

Project option 1.9.2 – Expand Specialty Care Capacity was chosen to address the extended wait times CCC patients experience when they need to access GI services. Long delays in accessing specialty care result in delayed GI related screenings, such as colonoscopies, which can prevent cancer. Additionally, expansion of GI capacity will allow local providers to enhance screening practices for Hepatitis C. Health screenings that can detect potentially serious health conditions before they worsen could significantly improve patient health outcomes and reduce costs to the health system.

Travis County residents who are low-income, uninsured or have public insurance coverage such as Medicaid, CHIP, or the local Medical Access Program (MAP) struggle with access to specialty care services due to lack of care capacity within the existing provider network serving this population. At the same time, the population in Central Texas is growing dramatically, placing a growing burden on the already strained network of specialty care providers dedicated to providing care to underserved populations.

Option 1.9.2 includes four required components:

e) **Increase service availability with extended hours.** Currently, GI clinic sessions are offered only three days per month to the existing MAP population at the UMCB specialty clinic. A limited number of clinic sessions are offered through a community-based setting. After a series of planning tasks, this project will begin by hiring providers to offer more care in community-based, outpatient settings. Hiring of additional providers will allow additional hours of care to be provided beginning in DY 2.
f) **Increase number of specialty clinic locations.** The project will increase the number of specialty clinic locations by placing newly hired providers at existing community-based outpatient settings that serve the population but do not yet provide GI services. The project will also develop a portion of the Southeast Health and Wellness Center, under renovation in southeast Austin, which will serve as a new specialty care site. Care offered at the new location will be in addition to care expanded at existing sites.
g) **Implement transparent, standardized referrals across the system.** GI specialty care will be provided within the context of the newly formed Community Care Collaborative (CCC). The CCC's function will be to monitor and coordinate care for the entire covered population. A robust referral system will be developed that will have standard operations across the entire network of care.
h) **Conduct quality improvement.** Expanded GI capacity will require careful planning, monitoring, and revision of expansion plans to ensure highest quality care to the patient population. Specialty providers will conduct continuous quality improvement activities that will be evaluated quarterly.

Reason for Selection of Milestones & Metrics

During DY 2, it is critical for the performing provider to complete a planning process (P-X: Complete a planning process) to understand how much additional capacity is needed and where it should be located to achieve the greatest expansions in care capacity. While this planning is occurring, the performing provider will begin the recruiting and hiring process (I-22: Increase the number of specialty providers) with a goal to provide additional patient visits (I-23: Increase specialty care volume of visits) as early as the second half of DY 2. New providers will be located at existing community-based sites.

In DY 3, to be launched in DY 4, the provider will complete a planning process (P-X: Complete a planning process) to prepare and then work to renovate the Southeast Health and Wellness Center to provide GI specialty care services to the target population. The Southeast Health and Wellness Center will be tailored to meet the specific care and cultural needs of the patient population. During this planning process, the CCC will evaluate adding additional capacity for preventive colorectal cancer screenings at the new location. In DY 2, 3, 4, and 5, the

provider will hire providers and provide care to additional patients. These milestones will grow over time as care is expanded at existing clinic sites and at the new site to open in DY 4.

Unique Community Need Identification Number

CN.2 Inadequate access to specialty care.

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

GI services are offered to the target population on a limited basis through the UMCB Specialty Clinic (hospital-based) and on a limited basis at a local FQHC. This project will build on and expand GI services offered in community-based settings to increase capacity in this area to benefit the target population.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

N/A

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

IT-1.1 Third Next Available Appointment

IT-1.20 Other Outcome Improvement Target – Annual Monitoring for Patients on Persistent Medications – boceprevir or telaprevir in combination with peginterferon alfa and ribavirin (Class 1, Level A)[1]

IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression

IT-12.3 Colorectal Cancer Screening (HEDIS 2012)

Reasons/Rationale for Selecting the Outcome Measure(s)

IT-1.1 Third Next Available Appointment: A primary goal of this project is to expand access to care as measured by reduced wait times for services, hence the selection of Third Next Available Appointment as an outcome measure.

IT-1.20 Other Outcome Improvement Target: Monitoring adherence to treatment protocols for patients on prescribed medication therapy – boceprevir or telaprevir in combination with peginterferon alfa and ribavirin (Class 1, Level A). Hepatitis C is a growing concern for Travis County safety net populations, yet treatment regimens are difficult to follow because treatment times last many weeks and the drugs have difficult side effects. The CCC's goal is to improve Hepatitis C treatment through better management of adherence to Hepatitis C drug regimens among

[1] American Association for the Study of Liver Diseases – 2011 Practice Guideline. http://www.aasld.org/practiceguidelines/Documents/2011UpdateGenotype1HCVbyAASLD24641.pdf The drug combination noted here is recommended for patients who have never received therapy for HCV.

newly-diagnosed patients, for which the above treatment regimen is recommended. The CCC expects that a majority of its Hepatitis C patients will not have had access to these treatments in the past, hence the choice of a drug regimen for newly-diagnosed patients.

IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression: Depression is common among patients with Hepatitis C and this condition may worsen during treatment. Screening for depression before treatment is crucial and may improve treatment outcomes. (Papafragkakis et al. "Depression and pegylated interferon-based hepatitis C treatment" *International Journal of Interferon, Cytokine, and Mediator Research.*March 2012, Volume: 2012:4, Pages 25-35). The CCC's goal is to ensure all patients diagnosed with hepatitis C are screened for depression and treated if necessary.

IT-12.3 Colorectal Cancer Screening (HEDIS 2012): In expanding capacity to provide colorectal cancer screening to the patient population, the CCC aims to catch colorectal cancer early to improve health outcomes.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This project reinforces other projects proposed by the CCC, including expanded access to primary and specialty care, and the development of standard protocols for the management of chronic diseases in the CCC population. The following projects are related most directly

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.7: Expanded Specialty Care Services at Community-Based Outpatient Settings: Pulmonary
- 307459301.1.5: Expanded Specialty Care Services at Community-Based Outpatient Settings: Musculoskeletal Services
- 307459301.1.3: Mobile Health Clinics
- 307459301.2.2: Chronic Care Management Protocols

List of Related Category 4 Projects (RHP Project ID Number)

RD-4: Medication management

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

176692501.1.1: Expanding Access to Specialty Care

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. Valuations for Category 3 projects associated with this Category 1 project are weighted according to the number of people expected to benefit from a particular outcome.

307459301.1.6	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY FOR GASTROENTEROLOGY***
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.6*	*IT-1.1*	*Third Next Available Appointment*
	307459301.3.7	*IT-1.8*	*Depression management: Screening and Treatment Plan for Clinical Depression*
	307459301.3.8	*IT-1.20*	*Other Outcome Improvement Target: Monitoring adherence to treatment protocols for patients on prescribed medication therapy – boceprevir or telaprevir in combination with peginterferon alfa and ribavirin (Class 1, Level A).*
	307459301.3.9	*IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Complete a planning process to evaluate the optimal way to expand gastroenterology service capacity across the system. Metric 1 [P-X.1]: Written documentation of a gastroenterology service capacity expansion plan. Baseline/Goal: 0/1 plan Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,065,386 **Milestone 2** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties.	**Milestone 4** [P-X]: Complete a planning process to prepare for the expansion of a clinic location. Metric 1 [P-X.1]: Written documentation of the specialty clinic facility plan. Baseline/Goal: 0/1 plan Data Source: Program records Milestone 4 Estimated Incentive Payment *(maximum amount):* $984,002 **Milestone 5** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of specialist providers	**Milestone 7** [P-11]: Launch/expand a specialty care clinic. Metric 1 [P-11.1]: Establish/expand a specialty care clinic. Goal: Launch a new specialty care clinic location. Data Source: Documentation of clinic operations. Milestone 7 Estimated Incentive Payment: $961,807 **Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number	**Milestone 10** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of specialist providers Baseline/Goal: 0.5 GI physician FTEs/2.0 additional GI physician FTEs over baseline Data Source: Human resources records Milestone 10 Estimated Incentive Payment *(maximum amount):* $1,165,266 **Milestone 11** [I-23]: Increase specialty care clinic volume of visits and

307459301.1.6	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY FOR GASTROENTEROLOGY***
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.6*	*IT-1.1*	*Third Next Available Appointment*
	307459301.3.7	*IT-1.8*	*Depression management: Screening and Treatment Plan for Clinical Depression*
	307459301.3.8	*IT-1.20*	*Other Outcome Improvement Target: Monitoring adherence to treatment protocols for patients on prescribed medication therapy – boceprevir or telaprevir in combination with peginterferon alfa and ribavirin (Class 1, Level A).*
	307459301.3.9	*IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Metric 1 [I-22.1]: Increase the number of specialist providers Baseline/Goal: 0.5 GI physician FTEs/0.27 addition GI physician FTEs over baseline Data Source: Human resources records Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,065,386	Baseline/Goal: 0.5 GI physician FTEs/1.0 additional GI physician FTEs over baseline Data Source: Human resources records Milestone 5 Estimated Incentive Payment *(maximum amount):* $984,002 **Milestone 6** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.	of specialist providers Baseline/Goal: 0.5 GI physician FTEs/1.5 additional GI physician FTEs over baseline Data Source: Human resources records Milestone 8 Estimated Incentive Payment *(maximum amount):* $961,807 **Milestone 9** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for	evidence of improved access for patients seeking services. Metric 10 [I-23.1]: Documentation of increased number of visits Baseline/Goal: 1,343 GI visits/2,570 additional GI visits over baseline Data Source: Clinical encounter data Milestone 10 Estimated Incentive

307459301.1.6	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY FOR GASTROENTEROLOGY***
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.6*	*IT-1.1*	*Third Next Available Appointment*
	307459301.3.7	*IT-1.8*	*Depression management: Screening and Treatment Plan for Clinical Depression*
	307459301.3.8	*IT-1.20*	*Other Outcome Improvement Target: Monitoring adherence to treatment protocols for patients on prescribed medication therapy – boceprevir or telaprevir in combination with peginterferon alfa and ribavirin (Class 1, Level A).*
	307459301.3.9	*IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3 [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits Baseline/Goal: 1,343 GI visits/ 170 additional GI visits over baseline Data Source: Clinical encounter data Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,065,385	Metric 1 [I-23.1]: Documentation of increased number of visits Baseline/Goal: 1,343 GI visits/1285 additional GI visits over baseline Data Source: Clinical encounter data Milestone 6 Estimated Incentive Payment *(maximum amount):* $984,002	patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits Baseline/Goal: 1,343 GI visits/1928 additional GI visits over baseline Data Source: Clinical encounter data Milestone 9 Estimated Incentive Payment *(maximum amount):* $961,806	Payment *(maximum amount):* $1,165,265
Year 2 Estimated Milestone Bundle Amount:: $3,196,157	Year 3 Estimated Milestone Bundle Amount: $2,952,006	Year 4 Estimated Milestone Bundle Amount: $2,885,420	Year 5 Estimated Milestone Bundle Amount: $2,330,531
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $11,364,114			

Performing Provider: Community Care Collaborative
Project Name: Expand Specialty Care Capacity for Pulmonology
Project Identifier: 307459301.1.7 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): This project will expand access to pulmonology specialty services for uninsured, underinsured, Medicaid, and Medicare patients by contracting with and/or hiring pulmonologists and support staff to serve in community-based settings as part of the CCC's provider network. The project will also support the development of a new multispecialty clinic to be located in Southeast Travis County.

Need for the project: Wait times for appointments to see a pulmonologist average four months. The clinic's pulmonologists are contracted to provide sixteen clinic sessions per year and are currently going beyond their contract to provide twenty clinic sessions per year. Even with the additional pro bono services, the pulmonology clinic is not available at all for two and a half months out of the year. If a patient presents in the emergency room with a serious lung disease during the months when the clinic is closed, that patient must be admitted to the hospital to receive services. According to the Texas Department of State Health Services (DSHS), COPD is one of the leading causes of death in Region 7. Not surprisingly, DSHS also finds that COPD is also one of the leading contributors of potentially preventable hospitalization costs in the region between 2005 and 2010.

Target population: The CCC will initially cover 50,000 patients at or below 200% of poverty. This project will provide pulmonary care to an additional 2,400 patients.

Category 1 or 2 expected patient benefits: The project will provide an additional 2,400 people with access to pulmonology specialty care services. The CCC will provide care for uninsured and Medicaid covered Travis County residents. Community-based settings where additional pulmonologists will be stationed served a high percentage of Medicaid patients. Thus, a portion of the benefit of the additional providers will extend to that population as well.

Category 3 outcomes: The CCC expects that the project will result in reduced COPD hospital admissions.

IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5

Title of Project: **Expand Access to Specialty Care for Pulmonology**
Category / Project Area / Project Option: **1.9.2 Expand Access to Specialty Care**
RHP Project Identification Number: **307459301.1.7**
Performing Provider Name: **Community Care Collaborative**
Performing Provider TPI: **307459301**

Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

This project will expand access to pulmonology specialty services for 2,400 uninsured, underinsured, Medicaid, and Medicare patients by contracting with and/or hiring pulmonologists and support staff to serve in community-based settings as part of the CCC's provider network. The project will also support the development of a new multispecialty clinic to be located in Southeast Travis County. The expansion of pulmonology services capacity is expected to reduce hospital admissions for Chronic Obstructive Pulmonary Disorder (COPD) among the target population. These patients will benefit from expanded access to pulmonology services as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project

Currently, pulmonology services are available to the target population primarily at the University Medical Center Brackenridge (UMCB) Specialty Clinic, a hospital-based clinic in downtown Austin. Wait times for appointments to see a pulmonologist average four months. The clinic's pulmonologists are contracted to provide sixteen clinic sessions per year and are currently going beyond their contract to provide twenty clinic sessions per year. Even with the additional pro bono services, the pulmonology clinic is not available at all for two and a half months out of the year. If a patient presents in the emergency room with a serious lung disease during the months when the clinic is closed, that patient must be admitted to the hospital to receive services.

According to the Texas Department of State Health Services (DSHS), COPD is one of the leading causes of death in Region 7. Not surprisingly, DSHS also finds that COPD is also one of the leading contributors of potentially preventable hospitalization costs in the region between 2005 and 2010. According to the City of Austin Health and Human Services Department, tobacco use, a primary contributor to pulmonary diseases, is the leading cause of preventable death in Travis County.

This project will expand the capacity to provide pulmonology services to 2,400 uninsured, underinsured, Medicaid, and Medicare patients by hiring additional providers and support staff to practice in existing community-based clinics within the constellation of the CCC provider network. Additional pulmonologists will rotate among primary care homes in the CCC network to maximize geographic access to this service. All primary care homes in the CCC provider network will also be equipped to provide spirometry services to assist in diagnosing pulmonary health issues for use by the pulmonologists during their clinics at those locations. By expanding specialty care into community-based clinics that serve as the target population's medical home, care will be more accessible and more likely to be provided in an environment that is more familiar and comfortable to the patient. The project will also support the development of an additional community-based multi-specialty clinic that will begin operation in southeast Travis County. Southeast Travis County has consistently been identified as an area with high levels of poverty and limited healthcare infrastructure. Approximately 270,000 people reside within a 5-mile radius of the proposed Southeast Health and Wellness Center, and 46% live below 200% of the Federal Poverty Level. Finally, CCC providers, including pulmonologists will conduct continuous quality improvement that will be evaluated quarterly.

Project Goals

- Expand specialty care capacity in community-based settings for pulmonology services for the target population.
- Decrease the percentage of potentially preventable admissions for Chronic Obstructive Pulmonary Disorder (COPD) among the target population.
- Increase the number of pulmonologists offering services to the target population
- Expand the number of specialty care facilities offering care to the target population by providing pulmonary services at a newly renovated clinic in Southeast Austin.

Challenges or Issues Faced by the Performing Provider

The performing provider anticipates that provider recruitment in this specialty will be a challenge. Safety net providers frequently struggle to recruit providers to serve their populations because the populations are perceived as challenging in that they may suffer from multiple chronic health conditions.

How the Project Addresses those Challenges

To address the provider recruitment challenge, the CCC will make aggressive efforts to outreach to residency programs that train physicians and other providers to provide these services. We will pay providers at competitive salaries, and, where possible, incorporate their services into local Federally Qualified Health Centers so the providers can access the benefit of Federal Tort Claims Act (FTCA) coverage. The provider will also locate these specialty services in the context of the patient's primary care medical home to make care more accessible, both geographically and in a care environment that is more comfortable and familiar to the patients and their families.

How the Project is Related to RHP Goals

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. Adding new providers, a new service line, and a new specialty care facility in community-based settings that provide care to the target population will significantly enhance the healthcare infrastructure available to provide care to low-income, uninsured, and Medicaid covered populations in Travis County.

2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. By providing more pulmonary care options in the outpatient setting, patients and families will have more convenient access to care for their lung diseases. Over time, this additional access will reduce health system costs by treating and managing patients with pulmonary illnesses and prevent inpatient admissions for COPD among the target population.

Five Year Expected Outcome

At the end of the demonstration period, two additional pulmonologists will be available to the target population, 2,400 additional patients will receive pulmonology services in community-based settings, a multi-specialty clinic site will be functioning in a high-need area of the county, and COPD admission rates are expected to decrease.

Starting Point/Baseline

Baseline Data

In 2011, there were 136 pulmonary visits to patients seen in the UMCB Specialty Clinic.

Time Period for Baseline

January - December 2011

Rationale

Reason for Selection of Project Options and Components

Travis County residents who are low-income, uninsured or have public insurance coverage such as Medicaid, CHIP, or the local Medical Access Program (MAP) struggle with access to specialty care services due to lack of care capacity within the existing provider network serving this population. During FY12, more than 13,000 patients served through MAP had a diagnosis for a chronic pulmonary disease, including COPD, asthma, emphysema, chronic bronchitis, and others. At the same time, the population in Central Texas is growing dramatically, placing a growing burden on the already strained network of specialty care providers dedicated to providing care to underserved populations. COPD is one of the leading causes of death in Region 7 and in Travis County and one of

the leading causes for potentially preventable hospital admissions, signifying a critical need for additional services to address unmet need for pulmonary care. Therefore, project option 1.9.2 – Expand Specialty Care Capacity - was chosen.

Option 1.9.2 includes four required components:

i) **Increase services availability with extended hours.** Currently, pulmonary clinic sessions are offered only two days per month. During DY 2, the project will implement a comprehensive planning process to identify the optimal scale and locations for pulmonary clinic expansion in the community. This project will begin by hiring providers to offer care in existing community-based, outpatient settings beginning in DY 3. More providers will allow the number of hours to provide care to increase over current levels.
j) **Increase number of specialty clinic locations.** The project will increase the number of specialty clinic locations by placing newly hired providers at existing community-based outpatient settings that serve the population but do not yet provide this type of service. The project will also develop a portion of a clinic under renovation in southeast Austin that will serve as a new specialty care site. Care offered at the new location will be in addition to care expanded at existing sites.
k) **Implement transparent, standardized referrals across the system.** Pulmonary specialty care will be provided within the context of the newly formed Community Care Collaborative (CCC). The CCC's function will be to monitor and coordinate care for the entire covered population. A robust referral system will be developed that will have standard operations across the entire network of care.
l) **Conduct quality improvement.** Expanded specialty care in pulmonary will require careful planning, monitoring, and revision of expansion plans as providers learn more about providing this service to this population in the context of the medical home. Specialty providers will conduct continuous quality improvement activities and will gather quarterly to discuss lessons learned and revise care delivery strategies.

Reason for Selection of Milestones & Metrics

Because pulmonology service in the outpatient setting is in such high demand among the target population, the performing provider will conduct a planning process in DY 2 to determine the optimal scale of the expansion and the locations where services will be provided. This work will be documented in a written expansion plan.

In DY 3, the provider will complete a planning process to prepare and then work to renovate a new specialty clinic to provide pulmonary specialty care services to the target population. This work will be documented in a written specialty clinic facility plan. The facility, which will become a multispecialty service site, will be tailored to meet the specific care and cultural needs of the patient population and will be open for services in early DY 4.

In DY 3, 4, and 5, the provider will hire providers and provide care to additional patients. These milestones will grow over time as care is expanded at existing clinic sites and at the new site to open in DY 4. Human resource records at CCC provider organizations will document the existence of newly contracted or hired pulmonologists.

Unique Community Need Identification Number

CN.2 Inadequate access to specialty care. This project will expand access to pulmonology services for uninsured, underinsured, Medicaid, and Medicare patients.

CN.18 Tobacco use remains a leading cause of preventable death. This project will increase the capacity of the performing provider to address tobacco related health issues.

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

Pulmonology services for uninsured, underinsured, Medicaid, and Medicare patients are available on an extremely limited basis. This project will expand pulmonologist availability to the target population.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

N/A

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-2: Potentially Preventable Admissions

IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5

Reasons/Rationale for Selecting the Outcome Measure(s)

Chronic obstructive pulmonary disease is one of the leading causes of death in Travis County and in Region 7 as a whole. The performing provider expects that expanding access to pulmonology services for the target population will allow their COPD to be addressed in a more timely way and will improve the ability to manage the patient's care in the outpatient setting. As a result, inpatient admissions for COPD are expected to decrease.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This project reinforces other projects proposed by the CCC, including expanded access to primary and specialty care, and the development of standard protocols for the management of chronic diseases in the CCC population.

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.3: Mobile Health Clinics
- 307459301.1.5: Expanded Specialty Care Services at Community-Based Outpatient Settings: Musculoskeletal Services
- 307459301.1.6: Expanded Specialty Care Services at Community-Based Outpatient Settings: Gastroenterology
- 307459301.2.2: Chronic Care Management Protocols

List of Related Category 4 Projects *(RHP Project ID Number)*

RD-1: Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate

RD-2: Chronic Obstructive Pulmonary Disease: 30 Day Readmissions

RD-2: All Cause – 30-Day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

This project relates to other projects in the RHP that expand primary and specialty care services (CTMC, St. Marks) in the following projects:

121789503.1.1: Expanding Primary Care

176692501.1.1: Expanding Access to Specialty Care

Within Travis County, the City of Austin's tobacco prevention project addresses the same problem from a different avenue (201320302.2.3).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected

on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

Potentially preventable hospitalizations for COPD contributed to almost $90 million in hospital charges in Travis County between 2005 and 2010. Based on estimates from the Texas Department of State Health Services, each COPD hospitalization averted through improved outpatient specialty care access could save approximately $27,616 in average hospital charges.

307459301.1.7	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY FOR PULMONOLOGY***	
Community Care Collaborative				***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.10*	*IT-2.5*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Complete a planning process to evaluate the optimal way to expand pulmonary service capacity across the system. Metric 1 [P-X.1]: Written documentation of a pulmonary service capacity expansion plan. Baseline/Goal: 0/1 plan Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,888,102	**Milestone 2** [P-X]: Complete a planning process to prepare for the expansion of a clinic location. Metric 1 [P-X.1]: Written documentation of the specialty clinic facility plan. Baseline/Goal: 0/1 plan Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $889,161 **Milestone 3** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of specialist providers Baseline: 0.05 Pulmonary physician FTE Goal: Increase of 1.0 FTE Pulmonary physicians over baseline Data Source: Human resources		**Milestone 5** [P-11]: Launch/expand a specialty care clinic. Metric 1 [P-11.1]: Establish/expand a specialty care clinic. Goal: Launch a new specialty care clinic location. Data Source: Documentation of clinic operations. Milestone 5 Estimated Incentive Payment: $869,105 **Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of specialist providers Baseline: 0.05 Pulmonary physician FTEs Goal: Increase of 1.5 FTE Pulmonary physicians over baseline	**Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Increase the number of specialist providers Baseline: 0.05 Pulmonary physician FTEs Goal: Increase of 2.0 FTE Pulmonary physicians over baseline Data Source: Human resources records Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,052,954 **Milestone 9** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 10 [I-23.1]: Documentation of increased number of visits

307459301.1.7	***1.9.2***	***1.9.2.A-D***	***EXPAND SPECIALTY CARE CAPACITY FOR PULMONOLOGY***
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.10*	*IT-2.5*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	records Milestone 3 Estimated Incentive Payment *(maximum amount):* $889,161 **Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits Baseline: 136 visits Goal: 1,846 increased visits over baseline Data Source: Clinical encounter data Milestone 4 Estimated Incentive Payment *(maximum amount):* $889,161	Data Source: Human resources records Milestone 6 Estimated Incentive Payment *(maximum amount):* $869,105 **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 Baseline: 136 visits Goal: 2,768 increased visits over baseline Data Source: Clinical encounter data Milestone 7 Estimated Incentive Payment *(maximum amount):* $869,104	Baseline: 136 visits Goal: 3,691 increased visits over baseline Data Source: Clinical encounter data Milestone 9 Estimated Incentive Payment *(maximum amount):* $1,052,953
Year 2 Estimated Milestone Bundle Amount: *:* $2,888,102	Year 3 Estimated Milestone Bundle Amount: $2,667,483	Year 4 Estimated Milestone Bundle Amount: $2,607,314	Year 5 Estimated Milestone Bundle Amount: $2,105,907
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $10,268,806			

Community Care Collaborative

Telepsychiatry in Community Health Clinics

307459301.1.8 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): The CCC will develop technology-assisted mental health services to expand access to mental health care for low-income uninsured and Medicaid patients accessing care at a local community healthcare clinic. This project also expands providers' capacity to access psychiatric consults when needed, improving provider's confidence in managing patients with mental health conditions. Protocols for tele-mental services will be developed to ensure consistent and effective use of the technology. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this DSRIP project will lead to better clinical outcomes for the patient, less reliance on acute and emergency care, and lowered costs of care for the indigent care system in Travis County.

Need for the project: Estimates suggest that over 50% of Travis County residents under 200% of the Federal Poverty Level require behavioral health care but are not receiving it (Central Health analyses for the Region 7 Community Needs Assessments). While many reasons exist for the lack of care, one reason is that the supply of and access to behavioral health clinicians is inadequate. The shortage is exacerbated for the low-income population.

Target population: This project will serve approximately 3,500 CCC patients who have a mental health Community healthcare clinics with limited access to behavioral health providers will be the initial focus of this project.

Category 1 or 2 expected patient benefits: This project will provide approximately 3,500 low-income uninsured and Medicaid patients with mental health services delivered via telemedicine. In DY3, 500 people will be served; DY4, 1200 people; DY5, 1800 people, for that 3500 persons total. Access to mental health care is expected to provide earlier diagnoses of patient's mental health conditions (e.g., depression and anxiety) and help monitor and manage their depression and anxiety.

Category 3 outcomes:
Outcome Domain 1, Primary Care and Chronic Disease Management

- IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710)
- IT-1.20 Other Outcome Improvement Target – Anxiety Management: Improvements on the Generalized Anxiety Disorder 7-item scale

Title of Project: Telepsychiatry in **Community** Health Clinics

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

RHP Project Identification Number: 307459301.1.8 Pass 3

Performing Provider Name: Community Care Collaborative (CCC)

Performing Provider TPI: 307459301

Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

The Telepsychiatry in Community Clinics Project will bring telemental services to approximately 3,500 patients with mental illnesses in the county's community healthcare clinics**.** These patients will benefit from telemental services as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Community Paramedic Navigator Project
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinic
- Integrated Behavioral Health
- Pregnancy Prevention
- STD & HIV Screening and Treatment & Referrals

Through installation of required equipment and conversion of treatment rooms, the following telemental services will be provided at community clinics in Travis County:

- Direct and continuing care to patients by behavioral specialists, delivered via telemedicine technology;

- Psychiatric consultations to primary care practitioners to assist with complex cases, medication management and reconciliation, triaging emergencies, addressing issues of co-morbidity;
- Expanded opportunities for staff training and education.

Project rollout will first target community clinics determined to be the most critically underserved in terms of behavioral health specialists and then expanded to other clinics over time.

CCC patients will gain access to the telemental service through PCP referral, which will be prompted or accompanied by administration of one of the standardized psychiatric assessments - the Patient Health Questionnaire (PHQ-9) a screening tool for depression, and the Generalized Anxiety Disorder (GAD-7) a screening tool for assessing generalized anxiety. In a dedicated, HIPAA-compliant treatment room at a community-based clinic, the patient will receive telemental treatment from a mental health provider, selected for his or her experience, availability and suitability to the patient. These treatments could range from one-time assessments and evaluations to a series of sessions as the patient's condition requires, with regular provider-to-provider follow up. Doctor-to-doctor consults also will occur via telemental services.

These technology-assisted services will give both patients and physicians access to behavioral health specialists and will result in many positive outcomes:

- Bringing behavioral health services to the primary care setting helps to increase positive patient outcomes due to increased opportunities for care, provides care in a familiar, non-threatening setting
- Increases opportunities to address high rates of behavioral health issues within the patient population by increasing access to mental health care.
- With on-demand telepsychiatry, services can immediately be applied in these clinic and providers' capacity to treat also will increase

Telemental health services fully realize the potential for the right level of service, in the right setting, at the right time.

Project Goals

The goals of this project are to:

- Provide technology-assisted behavioral health services into select clinical operations to over 3500 patients through installation of units and rooms at community health centers with the greatest immediate need;
- Increase patient and provider comfort and satisfaction with telemental services;
- See a reduction in patients' depression that accompanies telemental service utilization;
- See a reduction in patients' anxiety following telemental service utilization.

Challenges or Issues Faced by the Performing Provider

The main challenges with this project arise from the non-traditional way that behavioral health services will be delivered. Both patients and providers may need to gain comfort with a virtual behavioral health session. First, there is the delivery of care through a non-traditional medium. Second, there may be increased concern regarding patient privacy and the practice's HIPAA compliance.

How the Project Addresses those Challenges

During the first year of the Waiver, different models for telehealth, telemedicine, and tele-monitoring services will be evaluated, and clinic operations and protocols will be created based on assessments of best practices and practices

that can successfully integrate into existing facilities. Once established, providers will be familiarized with clinic operations and protocols related to telemental services (assessment, referral, processes for consultative services, etc.). Similarly, patients with the assistance of their clinicians will be familiarized with using telemental services to ensure a high level of comfort with using the technology. Patients referred to telemental services and are not comfortable with the use of technology-assisted services will have the option to use traditional services but will be informed that access to therapy via telemental services will be more expedient.

To address concerns regarding patient privacy and HIPAA compliance, secure networks, encryption programs and adherence to the national standards and best practices, such as those from the American Telemedicine Association, will be integrated into the CCC's new telemental service protocols (Gunter, Srihivsaraghavan, & Terry (2003), "Misinformed regulation of electronic medicine is unfair to responsible telepsychiatry", Journal of American Academy of Psychiatry and Law, 31:10–14.) also recommend the implementation of the following standards to ensure successful implementation of the technology: patient education regarding the equipment and scope of confidentiality, assessment of patient satisfaction with the service, on-going staff development and quality monitoring, and provision of local back-up to render care in a timely manner in case of emergency.

How the Project is Related to RHP Goals

This project is directly related to five of RHP 7's Regional goals:

- Goal 1: Prepare and develop infrastructure to improve the health of the current and future Region 7 populations
- Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems
- Goal 4: Bolster individual and population health by improving chronic disease management
- Goal 6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crises services and promotes recovery

Starting Point/Baseline

Baseline Data

At present, there are no telemental services currently being provided in the CCC's network of community-based safety net providers and therefore no patients are receiving telemental services. Telemental services will first be established in the community healthcare clinics with limited access to a mental health provider or currently do not have the capacity to hire a full-time psychiatrist.

Time Period for Baseline

NA

Rationale

Estimates suggest that over 50% of Travis County residents under 200% of the FPL require behavioral health care but are not receiving it (Central Health analyses for the Region 7 Community Needs Assessment). While many reasons exist for lack of care, one reason is that the supply of and access to behavioral health clinicians is inadequate. Central Texas is lacking medical specialists, and psychiatrists represent one of those shortages.

The shortage is exacerbated for the low-income population. In FY2011, two psychiatrists served as the sole consultative resource for 90 providers across the county's largest FQHC network. For individuals who qualify to receive state-funded services through the local mental health authority in Travis County, the wait time in fiscal year 12 was 120 days for service level 1 (medication and coordination), 81 days for service level 2 (Medication, coordination, and therapy). The purpose of tele-mental services is to address the community need for mental health services, such as medication management and therapy.

Telemental services bring benefits beyond increasing capacity to provide direct patient care. It also will be a needed consultative resource for primary care providers; approximately 48% of all psychotropic medications are prescribed by non-psychiatric primary care providers (Pincus et al, Journal of the American Medical Association, 279: 526-531, 1996).

Further, centralizing treatment in a convenient manner that minimizes barriers to access is a core component of the CCC's move towards a patient-centered medical network. Mental health treatment comes with its own set of innate barriers -social and cultural stigma- challenging in their own right without the added difficulty of negotiating transportation, waiting lists, or new facilities. Telepsychiatry minimizes these barriers by providing access to treatment in a familiar environment (the patient's medical home), minimizes wait times for mental health services, and can provide less-threatening access for crisis intervention.

Available resources and supports for the medically indigent must be leveraged both wisely and creatively. Tele-mental care offers an opportunity to maximize the reach of existing clinical skill to provide essential care in a place where patients are likely to be most familiar and comfortable.

Reason for Selection of Project Options and Components

Tele-mental services currently are not available in Travis County community-health clinics, therefore, one of the first activities for project implementation is the development of administrative and clinical protocols to serve as a manual of technology-assisted operations (1.11.2.a). A work group, guided by Central Health will be formed to assist in the identification of clinical best practices in the context of telemedicine. Once completed, this process will produce an action plan containing identified equipment needs as well as time frames for purchasing equipment training. Telemental services will first be implemented in the clinics with limited or no access to mental health services; these sites will serve as pilot sites for the project (1.11.2.b). The CCC will identify and train qualified behavioral health providers (1.11.2.c) to provide telemedicine, telehealth, tele-mentoring, or telemonitoring and to train primary care providers, specialty health providers on the use of the technology. And, in order to adequately track patient progress over time, the CCC will have to identify modifiers to track encounters performed via telehealth technology (1.11.2.d), and develop and implement data collection and reporting standards for electronically delivered services (1.11.2.e).The CCC will be a part of a learning collaborative on technology-assisted health care delivery. This collaborative will review the intervention(s) impact on access to specialty care and identify "lessons learned," opportunities to scale all or part of the intervention to a broader population, and identify key challenges associated with expansion (1.11.2.f). These lessons learned will be applied to the existing system, re-evaluated and retested as needed. Once the process and system are operating efficiently and effectively, the CCC will determine if the program can be scaled up to serve more people and at more locations (1.11.2.g). Lastly, this project will assess the impact of telemental services on patient outcomes (1.11.2.h) by evaluating changes in patient's mental health status.

Reason for Selection of Milestones & Metrics

The goal of this project is to increase access to behavioral health services through utilization of telemental technology in a network of primary health clinics. Since none of this technology is currently available in these settings and the specific needs, capacities and potentials have not yet been fully assessed, the selected milestones and metrics have been selected to align with a process of needs assessment, plan development, piloting, assessment, refinement and further implementation.

Furthermore, a number of RHP7 performing providers also are engaging in telemedicine. Learning collaboratives in DY3, 4, and 5 will be an opportunity for the providers to share best practices, challenges, and to learn from each other.

Unique Community Need Identification Number

CN.4 Inadequate access to behavioral health care

CN.6 Inadequate services throughout the continuum of care for individuals with behavioral health issues

CN.7 Lack of coordination of care across physical and behavioral health

CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

CN.15 Additive and costly impact of co-occurring mental health, substance abuse, and medical conditions

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

This is a new initiative.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

No known funded related activities

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-1: Primary Care and Chronic Disease Management

IT-1.9 Depression management: Depression Remission at Twelve Months (NQF#0710)

IT-1.20 Other Outcome Improvement Target - Anxiety Remission at Twelve Months

Reasons/Rationale for Selecting the Outcome Measure(s)

The goal of the intervention, access to mental health care via telemental services for low-income uninsured and Medicaid patients with multiple conditions is expected to improve this population's depressive symptomatology as measured by the Patient Health Questionnaire (PHQ-9). Access to the therapy, and coordinated care between primary care referring physician and the mental health provider (delivered via telemental services) should help this population better understand and manage their diseases (IT 1.9 Depression Management: Depression Remission at Twelve Months).

Anxiety disorders represented the second most prevalent (12% prevalence) mental health condition among low-income consumers at a Travis County FQHC. Access to mental health care via telemental services is expected to help improve consumers' levels of anxiety. The Generalized Anxiety Disorder (GAD-7) will be used to assess changes in consumers' anxiety (IT-1.20 Other Outcome Improvement Target).

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's 14 projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to this project are outlined below.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

307459301.2.1: Patient Centered Medical Home

307459301.2.2: Chronic Disease Management Models

307459301.2.3: Integrated Behavioral Health for Diabetics

137265806.1.3: Telepsych for the Emergency Department

List of Related Category 4 Projects *(RHP Project ID Number)*

RD-1.3: Potentially Preventable Admissions/ Behavioral Health and Substance Abuse Admission Rate

RD-2.3: 30-day Readmissions/Behavioral Health and Substance Abuse: 30-Day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Austin Travis County Integral Care (133542405.1.3) and Hill Country Mental Health and Developmental Disabilities Centers (133340307.2.12) propose using technology to provide telemental services.

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year. As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaborative - smaller meetings than the annual regional summit - that

will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.8	**1.11.2**	**1.11.2 (A-H)**	**Project Title: Telepsychiatry in Community Health Clinics**
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	**307459301.3.11** **307459301.3.12**	**IT – 1.9** **IT – 1.20**	**Depression Management: Depression Remission at Twelve Months** **Other Outcome Improvement Target/Improvements in the GAD-7**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-3]: Evaluate effective and efficient models for the delivery of telehealth, telemedicine, telemonitoring and telementoring services. Metric 1 [P-3.1]: Examine existing technology and models as well as information from leading providers of telemedicine, telehealth, telementoring, and telemonitoring services. Goal: Identify and select effective model for the delivery of tele-health and telemonitoring services Data Source: Review of the literature, findings from established working group Milestone 1 Estimated Incentive Payment: $ 750,054 ***Milestone 2 [P-2]* - Establish the number of providers and / or peer specialists in underserved**	**Milestone 4** [P-6]: Establish remote site locations where equipment will be available to consumers Metric 4 [P-6.1]: Documentation of site acquisition. Baseline: currently there are no sites with equipment, Goal: establish remote site location in 4 community health centers Data Source: Contract with provider Milestone 4 Estimated Incentive Payment: $ 415,655 **Milestone 5** [P-4]: Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment Metric 5 [P-4.1] : Inventory of new equipment purchased Goal: Equipment purchased at the	**Milestone 9 [I-15]: Satisfaction with telemental services** Metric 9 [I-15.1]: XX # % of consumer, peer and provider surveys indicate satisfaction with telemental services Goal: 50% of consumer surveys indicate satisfaction with telemental services; 50% of provider surveys indicate satisfaction with the use of telemental services Data Source: Survey data Milestone 9 Estimated Incentive Payment: $507,849 **Milestone 10 [P-14]. Participate in Face-to-Face Learning twice yearly** Metric 10 : Participate in semi-annual face-to-face meetings organized by	**Milestone 13 [I-15]: Satisfaction with telemental services** Metric 13 [I-15.1]: XX # % of consumer, peer and provider surveys indicate satisfaction with telemental services Baseline/Goal: 75% of consumer surveys indicate satisfaction with telemental services; 75% of provider surveys indicate satisfaction with the use of telemental services Milestone 13 Estimated Incentive Payment: $ 410,186 Milestone 14 [P-10.1]. **Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service** Metric: Project planning and implementation documentation that describes plan, do, study act quality

307459301.1.8	**1.11.2**	**1.11.2 (A-H)**	**Project Title: Telepsychiatry in Community Health Clinics**
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	**307459301.3.11** **307459301.3.12**	**IT – 1.9** **IT – 1.20**	**Depression Management: Depression Remission at Twelve Months** **Other Outcome Improvement Target/Improvements in the GAD-7**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
areas that have or do not have telecommunications equipment / software that can be **used to provide telemedicine, telehealth, telementoring or telemonitoring services.** **Further, determine the number of providers or peer specialists that would make use of** **such equipment / software if it were made available.** **Metric 2 [**P-2.1.] Survey of providers / peer organizations to identify need for and willingness to use advanced telecommunications equipment in the delivery or telemedicine, telehealth, telementoring, or telemonitoring. Goal: Survey all peer organizations in the CCC network of providers and identify the providers that have the	designated locations. Data Source: Documentation of equipment purchase Milestone 5 Estimated Incentive Payment: $ 415,655 **Milestone 6 [P-8]: Training for providers/peers on use of equipment/software** Metric 6 [P-8.1]: Documentation of completions of training on use of equipment/software Goal: 100% of participating staff at all selected tele-mental site locations are trained on use of equipment and software Data Source: Documentation of training completion Milestone 6 Estimated Incentive	the RHP Goal: Organize and facilitate two face-to-face meetings to discuss lessons learned from implementation of tele-mental services Data Source: Documentation of meeting and lesson learned Milestone 10 Estimated Incentive Payment: $ 507,849 **Milestone 11 [I-X]: Provide tele-mental services to patients** Metric 11 [I-X.1]. Number of patients served Goal: Provide services to 1200 additional CCC patients (516 with depression, 144 with anxiety, and 540 with another mental health diagnosis) Data Source: Patient records	improvement cycles Goal: Bi-weekly project reports that include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Project reports also will include output measures which describe the number and type of telemental transactions which occur. Data Source: Monthly reports Miletone 14 Estimated Incentive Payment: $ 410,186 **Milestone 15 [P-14]. Participate in Face-to-Face Learning twice yearly** Metric 15 Participate in semi-annual face-to-face meetings organized by the RHP Goal: Organize and facilitate two face-to-face meetings

307459301.1.8	**1.11.2**	**1.11.2 (A-H)**	**Project Title: Telepsychiatry in Community Health Clinics**
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	**307459301.3.11** **307459301.3.12**	**IT – 1.9** **IT – 1.20**	**Depression Management: Depression Remission at Twelve Months** **Other Outcome Improvement Target/Improvements in the GAD-7**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
greatest need. Data source: Provider / peer responses to the survey. Milestone 2 Estimated Incentive Payment: $ 750,054 **Milestone 3 [P-X]: Designate/hire personnel teams to manage interventions** Baseline: 0 hired Goal: 1 hired Data: Human resources data to indicate hire	Payment: $ 415,655 **Milestone 7 [I-X].** **Provide tele-mental services to patients** Metric 7 [I-X.1]. Number of patients served Goal: Provide tele-mental services to 500 CCC patients (215 diagnosed with depression, 60 diagnosed with anxiety, and 225 with another mental health diagnosis) Data Source: Patient records Milestone 7 Estimated Incentive	Milestone 11 Estimated Incentive Payment: $ 507,849 Milestone 12 [P-10.1]. **Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service** Metric: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles Goal: Bi-weekly project reports that include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Project reports also will include output measures which describe the number	Data Source: Documentation of meeting Milestone 15 Estimated Incentive Payment: $ 410,186 **Milestone 16 [I-X]: Provide telemental services to patients** Metric 16 [I-X.1]. Number of patients served Goal: Provide tele-mental services to 1800 additional CCC patients (776 with depression, 216 with anxiety and 810 with another mental health diagnosis)

307459301.1.8	**1.11.2**	**1.11.2 (A-H)**	**Project Title: Telepsychiatry in Community Health Clinics**	
Community Care Collaborative				***307459301***
Related Category 3 Outcome Measure(s):	**307459301.3.11** **307459301.3.12**	**IT – 1.9** **IT – 1.20**	**Depression Management: Depression Remission at Twelve Months** **Other Outcome Improvement Target/Improvements in the GAD-7**	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 3 Estimated Incentive Payment: $750,054	Payment: $ 415,655 **Milestone 8 [P-14]: Participate in Face-to-Face Learning twice yearly** Metric 8 : Participate in semi-annual face-to-face meetings organized by the RHP Goal: Organize and facilitate two face-to-face meetings to discuss trainings and how to improve training for providers at future sites Data Source: Documentation of meetings and lessons learned Milestone 8 Estimated Incentive Payment: $ 415,655		and type of telemental transactions which occur. Data Source: Monthly reports Miletone 12 Estimated Incentive Payment: $ 507,850	Data Source: Patient records Milestone 16 Estimated Incentive Payment: $ 410,185

307459301.1.8	**1.11.2**	**1.11.2 (A-H)**	**Project Title: Telepsychiatry in Community Health Clinics**
Community Care Collaborative			***307459301***
Related Category 3 Outcome Measure(s):	**307459301.3.11** **307459301.3.12**	**IT – 1.9** **IT – 1.20**	**Depression Management: Depression Remission at Twelve Months** **Other Outcome Improvement Target/Improvements in the GAD-7**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: $ 2,250,162	Year 3 Estimated Milestone Bundle Amount: $2,078,275	Year 4 Estimated Milestone Bundle Amount: $2,031,397	Year 5 Estimated Milestone Bundle Amount: $1,640,743

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $8,000,577

Dell Children's Medical Center (DCMC)
Category 1 DSRIP Projects

Provider: DELL CHILDREN'S MEDICAL CENTER (DCMC)
Project Title: School Campus Counseling
Project Identifier: 186599001.1.1 Pass 1

Provider: DCMC is the only Children's Hospital in the region. Austin proper has a population of approximately 820,000 and is located in Travis County, with a population of approximately 1.1 million. The hospital is part of a larger health care system, Seton Healthcare Family, through which it has access to an extensive network for primary, specialty, and emergency care.

Intervention(s): This project establishes school-based behavioral health clinics to increase access to behavioral health services for children and adolescents through the delivery of psychotherapy, psychiatric assessments and medication management. .

Need for the Project: This project addresses unmet behavioral health needs of school children. (CN.4). By supplementing the school's workforce with qualified behavioral healthcare professionals and providing free, on-campus behavioral services to low-income students, barriers to timely and appropriate care are reduced.

Target Population: The target population is at-risk children and adolescents referred for behavioral health services by Austin Independent School District ("AISD"). It will primarily serve low income students and/or students with barriers to accessing behavioral health care. . The population served is expected to be 50% Medicaid and 5% unfunded.

Category 1 or 2 Expected Patient Benefits: Through this project, 1,000 students will receive campus-based behavioral health services in DY2, 1,375 students in DY3, 1,500 students in DY4 and 2,000 students in DY5. By the end of DY5 5,375 children and adolescents will receive behavioral health services.

Category 3 Outcomes: . [IT-1.20] The number of patients (participants aged 6 through 17 years of age) with a diagnosis of major depressive disorder who have been assessed for suicide risk will increase by 3% over baseline in DY4 and by 5% over baseline in DY5. Baseline to be determined in DY3.

Title of Project: School Campus Counseling

Category / Project Area / 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: 186599001.1.1 Pass 1

Performing Provider Name Dell Children's Medical Center

Performing Provider TPI: 186599002

Dell Children's Medical Center proposes to increase access to behavioral health services through the delivery of psychotherapy, psychiatric assessments and medication management on school campuses to children and adolescents.

This project will create access to behavioral health services at the right time in the right place by identifying students with unmet behavioral health needs on the school campus and delivering behavioral health services on that campus. Each school year, this project will establish and operate one or more school-based behavioral health clinics; thereafter the established clinic(s) will be operated by AISD and no longer served by this project. Clinics will be opened at new schools each school year, with the number of students served increasing with each demonstration year.

This project will provide psychotherapy and medication management on campuses of select AISD schools, especially targeting students who have difficulty accessing services due to funding, transportation, or access to providers. Early identification of mental health needs and access to services is crucial to preventing the unnecessary use of crisis services. By providing services on the school campus, transportation burdens are alleviated as students will not need to leave the school campus to receive services and less classroom time is lost.

AISD is the fifth largest school district in Texas, serving 86,000 students at 124 schools, including 19 high schools. AISD has conducted detailed analyses of its school campuses to determine a variety of factors related to mental health issues and access to care, including rates of abuse, behavioral problems, gang activity, absenteeism, academic performance, involvement in extracurricular activities, parental involvement and socioeconomic status. These analyses have been used to prioritize the development of campus-based behavioral health care services. Numerous publications (http://rtckids.fmhi.usf.edu/sbmh/default.cfm) have identified school-based health care (including mental health care) as a best practice to deliver the right level of care in the right place at the right time.[2]

Referrals will flow through school staff who identify students with mental health needs. Students who need additional assessment by a psychiatrist will receive psychiatric assessment and intervention through telemedicine services without having to leave campus. Services will include medication management by a child psychiatrist, individual Cognitive Behavioral Therapy, family therapy and group therapy by a psychologist or licensed social worker. Meetings between AISD administration, campus-level administrators (principal, school nurses, and school counselors), administrators from the behavioral health providers, and the providers themselves will occur quarterly to discuss lessons learned, opportunities to improve the process, and how to further expand services to other campuses.

Goals and Relationship to Regional Goals:

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[2] Rones M, Hoagwood K. School Based Mental Health Services: A Research Review. Clinical Child and Family Psychology Review. 2000; 3(4): 223-241.

Project Goals:
The goal of this project is to avert outcomes such as potentially avoidable inpatient admission and readmissions in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community. This can be done by providing community based interventions for individuals to prevent them from cycling through multiple systems, such as the criminal justice system; the general acute and specialty psychiatric inpatient system; and the mental health system. This project will also focus on suicide prevention by ensuring students diagnosed with major depressive disorder are given a suicide-risk assessment.

The primary students that this project intends to reach are low-income students who cannot afford private mental health care or do not have access to transportation to get to mental health appointments during the day (because a parent cannot leave work to transport them or they cannot afford the transportation costs). By providing the services inside the school setting, students will be able to get to their appointments. This project will increase access to behavioral health services to 5,375 student.

Challenges:
A challenge faced by the local school district is that there is not adequate access to behavioral health services for students identified as needing services. To meet this need, there is strong interest in developing school-based behavioral health clinics. All 19 AISD high schools have demand for services on their campus but there is not adequate workforce to begin all those clinics simultaneously. AISD has created a system for assessing which schools have the greatest need and this will be used to prioritize and identify the schools served by this project.

This project meets the following regional goals:

- This project will provide access to care in the most convenient and accessible location for adolescents—their school (RHP Goal #2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting).
- We are focused on wellness and promote recovery (RHP Goal #6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery).

Starting Point/Baseline:
AISD began a pilot project with Seton Healthcare Family and LoneStar Circle of Care (a Federally Qualified Health Center with a large behavioral health service line) that ran from 03/01/12 through 08/30/12 at a school campus not a served by this project. . This project expands the pilot to schools that have no access to on-site behavioral health services; the baseline for this project is zero.

Rationale:

Texas school counselors serve a ratio of 500 students per one counselor and Texas school counselors are not trained or licensed to deliver psychotherapy. School staff and nurses consistently identify students with unmet mental health needs. Even when staff or nurses can refer students and families to community providers, many students have funding and/or transportation issues that make going to appointments challenging.

As is demonstrated from the data below (standardized data collected for all students enrolled in AISD), mental health issues including depression, bullying, interpersonal conflict, and concerns about safety impact many students within AISD.

Q9: During the last month, did you miss one or more school days due to any of the following reasons?	All high schools 2009-2010	All high schools 2010-2011	Δ*	All middle schools 2009-2010	All middle schools 2010-2011	Δ*
Was sick	59%	58%	-1	57%	57%	0
Didn't feel safe at school	4%	6%	2	5%	5%	0
Didn't feel safe on the way to/from school	4%	4%	0	4%	5%	1
Didn't get along well with teachers	11%	11%	0	9%	9%	0
Wanted to hang out with friends	21%	21%	0	9%	10%	1
Had to do something with family	37%	38%	1	25%	32%	7
Was too tired	35%	33%	-2	20%	19%	-1
Didn't have a way to get to school	15%	15%	0	10%	9%	-1
Felt too sad or depressed to attend †	N/A	15%	N/A	N/A	10%	N/A
Had to go to work †	N/A	7%	N/A	N/A	3%	N/A
None	19%	24%	5	26%	30%	4
Q10: During this school year, have you experienced any of the following types of bullying at school?	All high schools 2009-2010	All high schools 2010-2011	Δ*	All middle schools 2009-2010	All middle schools 2010-2011	Δ*
Social	25%	20%	-5	33%	30%	-3
Verbal	25%	21%	-4	39%	35%	-4
Written	5%	5%	0	9%	8%	-1
Sexual Harassment	11%	10%	-1	2%	11%	-1
Racial or Ethnic Harassment	17%	15%	-2	19%	18%	-1
Cyber bullying	8%	8%	0	9%	8%	-1
Hurtful or controlling dating behavior †	N/A	7%	N/A	N/A	8%	N/A
None	56%	61%	5	40%	45%	5

http://www.austinisd.org/sites/default/files/dre-surveys/District-SSUSS_2011.pdf

The *Code Red: The Critical Condition of Health in Texas 2012* report, authored by a task force comprised of all ten of the major academic health institutions in Texas, states access to mental health services remains a major problem for Texas. The report also recommends that communities screen children and adults for behavioral health issues in the school setting (www.coderedtexas.org). The *Report to Senator Kirk Watson 10in10 Initiative: Item No. 7 – Behavioral Health* Services, co-authored by Central Health and Austin Travis County Integral Care in May 2012 states: "Stakeholders who work with children strongly recommend expansion of services in the schools. School-based services provide readily available access in a less stigmatizing environment and are considered a national best practice."

During the 2010-11 school year, schools across AISD were assessed for the number of kids determined to be "at risk" and in need of mental health services as well as looking at the number of kids with low socioeconomic status. Principals were asked to complete a questionnaire to determine their level of support for a mental health clinic on their campus and whether they had the space and staff available to support such a clinic. From this process, AISD identified two schools to begin mental health clinics during the 2012-13 school year.

Project Components:
This Project Option has no required core components.

Unique community need identification numbers the project addresses:
This project addresses several community needs identified in the RHP:

- CN.4 - Inadequate access to behavioral health care
- CN.6 - Inadequate services throughout the continuum of care for individuals with behavioral health issues
- CN.15 - Additive and costly impact of co-occurring mental health, substance use, and medical conditions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is the expansion of a pilot program that was funded through the *Safe Schools, Healthy Students* grant that was administered by the Dept. of Education, Justice, & Health and Human Services to AISD to provide start-up costs for school-based mental health services. Grant funds were provided for services from 03/01/12 through 08/30/12 at an AISD high school campus not served by this intervention.

Related Activities Funded by U.S. Dept. of Health and Human Services:
This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives. Performing Provider, DCMC participates in the *Medicare and Medicaid Electronic Health Records* for hospitals; extension of this program to DCMC-affiliated physician offices and clinics is in development; participation in the EHR program is expected to support the care delivered under this project and coordination between providers. DCMC is an awardee in an HHSC capital grant (HRSA-11-127) to add telecommunications and medical peripheral equipment to a pediatric mobile medical vehicle, but such services are not related to this project. DCMC is also a sub-awardee for a research study awarded to University of Texas Health Science Center – Houston (Prime Award #1U18DP003367-01/Subaward #8773E for the study of childhood obesity; this contract does not duplicate or fund services provided through this intervention.

Related Category 3 Outcome Measure(s)

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OD-1 Primary Care and Chronic Disease Management

IT-1.20 Other Outcome Improvement Target: Increase the number of patient visits for program participants aged 6 through 17 years of age with a diagnosis of major depressive disorder with an assessment for suicide risk. 2010 Sep. NQMC:004438[3]

Reasons/rationale for selecting the outcome measures:
This evidence-based measure was selected because Central Texas has been flagged and monitored by the CDC for the past several years as a Suicide Cluster for adolescents given the high rate of adolescent suicide. Although psychotherapy is recommended for children and adolescents with a diagnosis of major depressive disorder, research has indicated that it is currently underutilized and declining in use. In 2001-2002, approximately 68% of children and adolescents being treated for major depressive disorder received psychotherapy or mental health counseling, a 15% decrease from 6 years earlier.[4]

Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment an important aspect of care that should be assessed at each visit. Suicidal behavior exists along a continuum from passive thoughts of death to a clearly developed plan and intent to carry out that plan. Because depression is closely associated with suicidal thoughts and behavior, it is imperative to evaluate these symptoms at the initial and subsequent assessments. Also, it is crucial to evaluate the risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that might influence the desire to attempt suicide. The risk for suicidal behavior increases if there is a history of suicide attempts, comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse), impulsivity and aggression, availability of lethal agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence), and a family history of suicidal behavior. (AACAP, 2007)

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Relationship to other Projects:
This project relates to Dell Children's two other projects through similar target populations.
186599001.2.1 - Dell Children's Medical Center - Family and Child Obesity
186599001.2.2 - Dell Children's Medical Center - Chronic Care Management – Pediatrics

List of Related Category 4 Projects
OD-1, Potentially Preventable Admissions and OD-4, Patient Satisfaction

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative
This project will complement other behavioral health projects designed to expand access to care. This project also complements other projects designed to provide the right level of care in the right location and the right time. Performing provider has ensured that all project plans are based upon community needs and operate in conjunction with the RHP-wide initiatives. Furthermore, this proposed project meets the needs of the specific population and will not duplicate services of other performing provider projects in the RHP.

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[3]Physician Consortium for Performance Improvement®. Child and adolescent major depressive disorder physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2010 Sep. 30 p. [13 references]

[4] Ma J, Lee KV, Stafford RS. Depression treatment during outpatient visits by U.S. children and adolescents. J Adolsce Health. 2005 Dec; 37 (6): 434-42.

This project relates to the following projects being implemented by other providers in RHP 7:
126844305.1.1 - Bluebonnet Trails Community Services - Youth Counseling in Schools for Fayette and Lee Counties

126844305.1.2 - Bluebonnet Trails Community Services - Child Crisis Respite through Therapeutic Foster Care
137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department
133542405.1.1 - Austin Travis County Integral Care - Mental Health First Aid and Suicide Prevention

Provider will fully participate in RHP-wide learning collaboratives for projects that directly address chronic care management. Because of the wide scope of such services and the integration of care at all levels, plans to participate in learnings regarding care transitions, enhancement of interpretation services, culturally competent care, palliative care and telemed. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically.

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. Through early identification and treatment of mental health conditions, this project is expected to reduce preventable hospital admissions, crisis psychiatric services and emergency room visits.

This project will reach primarily low-income students who cannot afford private mental health care or do not have access to transportation to get to mental health appointments during the day (because a parent cannot leave work to transport them or they cannot afford the transportation costs). By treating mental health needs of children, school absenteeism will be reduced and students will to take full advantage of educational opportunities.

UNIQUE IDENTIFIER: 186599001.1.1	RHP PP REFERENCE NUMBER 1.12	PROJECT COMPONENTS: *NONE*	1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Behavioral Health School Campus Program	
Performing Provider: Dell Children's Medical Center				TPI: 186599001
Related Category 3 Outcome Measure(s):	186599001.3.1	IT-1.20	**Other Outcome Improvement Target**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Milestone: Hire and train staff to operate and manage projects selected. Metric 1 [P-4.1]. Number of staff secured and trained. Goal: Hire and train 2 staff to operate each campus-based clinic established in DY2. Data Source: Project Administrative Records Milestone 1 Estimated Incentive Payment:$ 126,879	**Milestone 4** [P-4]: Milestone: Hire and train staff to operate and manage projects selected. Metric 1 [P-4.1]: Number of staff secured and trained. Goal: Hire and train 2 staff to operate each campus-based clinic established in DY2. Data Source: Project Administrative Records Milestone 4 Estimated Incentive Payment : $238,831		**Milestone 7** [P-4]: Milestone: Hire and train staff to operate and manage projects selected. Metric 1 [P-4.1]: Number of staff secured and trained. Goal: Hire and train 2 staff to operate each campus-based clinic established in DY2. Data Source: Project Administrative Records Milestone 7 Estimated Incentive Payment : $223,904	**Milestone 10** [P-4]: Milestone: Hire and train staff to operate and manage projects selected. Metric 1 [P-4.1]: Number of staff secured and trained. Goal: Hire and train 2 staff to operate each campus-based clinic established in DY2. Data Source: Project Administrative Records Milestone 10 Estimated Incentive Payment : $170,167
Milestone 2 [I-X]: Milestone: Increased utilization of community behavioral healthcare services Metric 1 [I-X.1]: Increase the number of target population reached Baseline: This is a new program; baseline at DY2 is zero Goal: 1,000 students will receive	**Milestone 5** [I-X]: Milestone: Increased utilization of community behavioral healthcare services Metric 1 [I-X.1]: Increase the number of target population reached Baseline: This is a new program; baseline at DY2 is zero Goal: 1,375 students will receive		**Milestone 8** [I-X]: Milestone: Increased utilization of community behavioral healthcare services Metric 1 [I-X.1]: Increase the number of target population reached Baseline: This is a new program; baseline at DY2 is zero Goal: 1,500 students will receive	**Milestone 11** [I-X]: Milestone: Increased utilization of community behavioral healthcare services Metric 1 [I-X.1]: Increase the number of target population reached Baseline: This is a new program; baseline at DY2 is zero Goal: 2,000 students will receive

UNIQUE IDENTIFIER: 186599001.1.1	RHP PP REFERENCE NUMBER 1.12	PROJECT COMPONENTS: *NONE*	1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Behavioral Health School Campus Program	
Performing Provider: Dell Children's Medical Center				TPI: 186599001
Related Category 3 Outcome Measure(s):	186599001.3.1	IT-1.20	**Other Outcome Improvement Target**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
campus-based behavioral health services. Data source: Internal program registration and encounter log. Milestone 2 Estimated Incentive Payment: $126,879 **Milestone 3** [P-10]: . Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-10.1 :] Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	campus-based behavioral health services. Data source: Internal program registration and encounter log. Milestone 5 Estimated Incentive Payment: $238,831 **Milestone 6** [P-10]: . Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Metric 1** [P-10.1 :] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year. Data Source: Documentation of semi-		campus-based behavioral health services. Data source: Internal program registration and encounter log. : Milestone 8 Estimated Incentive Payment: $223,904 **Milestone 9** [P-10]: . Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-10.1 :] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year. Data Source: Documentation of semi-	campus-based behavioral health services. Data source: Internal program registration and encounter log. : Milestone 11 Estimated Incentive Payment: $170,167 **Milestone 12** [P-10]: . Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-10.1 :] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year. Data Source: Documentation of semi-

UNIQUE IDENTIFIER: 186599001.1.1	RHP PP REFERENCE NUMBER 1.12	PROJECT COMPONENTS: ***NONE***	1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Behavioral Health School Campus Program	
Performing Provider: Dell Children's Medical Center				TPI: 186599001
Related Category 3 Outcome Measure(s):	186599001.3.1	IT-1.20	**Other Outcome Improvement Target**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: Participate in face-to-face learnings at least twice per year. Data Source: Documentation of semi-annual meetings including agendas, slides from presentation and/or meeting notes. Milestone 3 Estimated Incentive Payment: $ 126,879	annual meetings including agendas, slides from presentation and/or meeting notes. Milestone 6 Estimated Incentive Payment: $238,831		annual meetings including agendas, slides from presentation and/or meeting notes. Milestone 9 Estimated Incentive Payment: $223,904	annual meetings including agendas, slides from presentation and/or meeting notes. Milestone 12 Estimated Incentive Payment: $170,167
Year 2 Estimated Milestone Bundle Amount: $380,637	Year 3 Estimated Milestone Bundle Amount: $***716,493***		Year 4 Estimated Milestone Bundle Amount: $671,712	Year 5 Estimated Milestone Bundle Amount: $510,501
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $2,279,343				

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Category 1 DSRIP Projects

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Hays County Mental Health Center Mobile Clinic

133340307.1.1 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will develop a Mobile Clinic to provide comprehensive behavioral health services (including Case Management, Counseling, Pharmacological Management, Medication Training and Support, Psychiatric Rehabilitation, Skills Training, Engagement Activities, Supported Employment and Supported Housing) to outlying areas of Hays and Blanco counties. Our goal is to reduce emergency department (ED) utilization, inpatient utilization, and incarceration by ensuring availability of services to outlying portions of the service area.

Need for the project: According to *Health is Mental*, a publication of the National Council, 1 in 5 or 20% of people suffer from mental illness and 49% of Medicaid beneficiaries with disabilities have a mental illness. Based on the estimated populations of Hays and Blanco counties by the Department of State Health Services of 189,943 for 2012 and with the Hays County Mental Health Clinic serving 1,462 individuals from July 2011 through June 2012, there is currently less than 1% penetration rate for individuals receiving mental health services.

Target population: The target population includes individuals in outlying areas of Hays and Blanco counties who have a mental illness. The project is targeting a minimum of 287 additional individuals receiving services by the end of DY5 (number beginning service by DY: DY3 50; DY4 100; and DY5 137). Based on the population served in Hill Country's existing behavioral health program in RHP 7, it is anticipated that approximately 30% of our patients within RHP 7 have Medicaid and approximately 75% have income below $15,000 per year. We expect the target population will be similar to this.

Category 1 or 2 expected patient benefits: The project aims to establish COPSD services in a community setting within Hays County served by Hill Country in RHP 7 which will reduce inappropriate ED use and incarceration. The project seeks to provide services to a minimum of 287 individuals from Hays County served by Hill Country in RHP 7 by the end of DY5 (number beginning service by DY: DY3 50; DY4 100; and DY5 137). **Category 3 outcomes:** IT-10.2 Activities of Daily Living (DLA-20). Our goal is to have, at a minimum, 20% of the individuals served by the Mobile Clinic services showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, inappropriate ED use and incarceration.

Title of Project: Hays County Mental Health Center Mobile Clinic

Category / Project Area / Project Option: 1.12 Enhance service availability of appropriate levels of behavioral health care
1.12.3 Develop and staff a number of mobile clinics that can provide access to care in very remote, inaccessible, or impoverished areas of Texas

RHP Project Identification Number: 133340307.1.1 Pass 2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description
Hill Country MHDD Centers plan to develop a Mobile Clinic to provide comprehensive behavioral health services (including Case Management, Counseling, Pharmacological Management, Medication Training and Support, Psychiatric Rehabilitation, Skills Training, Engagement Activities, Supported Employment and Supported Housing) to outlying areas of Hays and Blanco counties. Currently, the Hays County Mental Health Clinic located in San Marcos serves all of Hays and Blanco counties, a service area of 1,390 square miles with limited, if any, public transportation available. The Hays County Mental Health Clinic is the only public behavioral health provider with the two counties. According to *Health is Mental*, a publication of the National Council, 1 in 5 or 20% of people suffer from mental illness and 49% of Medicaid beneficiaries with disabilities have a mental illness. Based on the estimated populations of Hays and Blanco counties by the Department of State Health Services of 189,943 for 2012 and with the Hays County Mental Health Clinic serving 1,462 individuals from July 2011 through June 2012, there is currently less than 1% penetration rate for individuals receiving mental health services. By providing a Mobile Health Clinic for behavioral health services that travels to outlying areas such as Dripping Springs, Johnson City, Kyle, and Wimberley; Hill Country anticipates increasing the penetration rate to over 1.5% of the population in order to address behavioral health symptoms before they become a crisis and utilize emergency department and hospital services.

The Mobile Clinic will have case workers, nurses and psychiatrists (either physically or via telemedicine) available in the individuals home community. Staffing for the Mobile Clinic will be in addition to current staffing at the Hays County Mental Health Center to ensure that expanded capacity for services is achieved.

Project Goals
The goal of this project is to provide a Mobile Health Clinic for behavioral health services that provides services to outlying areas of Hays and Blanco counties. The project will enable more individuals to receive treatment for mental illness by bringing case workers, nurses, and psychiatrists (physically or through telemedicine) to the individuals home communities instead of requiring them to travel to receive services. By Demonstration Year 5, the goal is to have a minimum of 1.5% penetration rate of the population within Hays and Blanco counties receiving mental health services.

Challenges or Issues Faced by the Performing Provider
The primary challenges to implementing the project are recruitment of staff for mobile services and obtaining appropriate vehicle and satellite services for mobile services. Hill Country will offer incentives to acquire staff as necessary, will prioritize staff with commercial driver's license, and will begin planning with receiving bids and acquiring mobile vehicle with needed secure satellite services.

How the Project is Related to RHP Goals
This project is related to the following RHP 7 Goals:

- Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

Starting Point/Baseline

Baseline Data Currently the Hays County Mental Health Clinic does not offer a Mobile Clinic for provision of services.

Rationale

Reason for Selection of Project Options and Components
Hill Country MHDD Centers plans to develop a Mobile Clinic to provide services to outlying areas of Hays and Blanco counties. The project will increase availability of mental health services and enable individuals in outlying areas of Hays and Blanco counties to receive mental health services without having the additional expense and time commitment currently required of traveling to San Marcos to receive services at the Hays County Mental Health Clinic. By Demonstration Year 5, the goal is to have a minimum of 1.5% penetration rate of the population within Hays and Blanco counties receiving mental health services.

In designing a Mobile Clinic for the outlying areas of Hays and Blanco counties, Hill Country MHDD Centers will:

A) Identify areas which lack sufficient public transportation to assist individuals with mental illness with transportation to appointments.
B) Identify any necessary licenses, equipment requirements and other components needed to implement and operate a mobile clinic.
C) Develop administrative protocols and clinical guidelines for a mobile clinic.
D) Hire and train staff to operate and manage a mobile clinic.
E) Determine appropriate locations and frequency of visits of the Mobile Clinic to the most appropriate locations within Hays and Blanco counties.
F) Acquire data reporting, communication and collection tools to be used in the mobile clinic setting.
G) Develop and implement data collection and reporting mechanisms and standards to track the utilization mobile clinic services as well as the health care outcomes of individual treated in the mobile clinic service setting.

H) Conduct quality improvement for the mobile clinic using methods such as rapid cycle improvement. Hill Country will conduct on-going consumer satisfaction surveys for mobile clinic services.

Reason for Selection of Milestones and Metrics

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals beginning services through the Mobile Clinic to ensure the project is operational during DY3. DY4 and DY5 have number of new individuals beginning services through the Mobile Clinic and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future

Unique Community Need Identification Number

CN.7 Lack of coordination of care across settings of care, multiple conditions, and physical and behavioral health

CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions.

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

The Hays County Mental Health Center does not currently offer mobile clinic services to outlying areas of Hays and Blanco counties.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-10 Quality of Life/Functional Status

IT-10.2 Activities of Daily Living

Reasons/rationale for Selecting the Outcome Measure(s)

Mobile Clinic Services impact an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. By offering mental health services in the local community individuals are more likely to receive needed services and improve their mental health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

How Project Supports, Reinforces, Enables Other Projects

Provision of the Mobile Clinic services in the outlying areas of Hays and Blanco counties as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, 133340307.4 Trauma Informed Care, 133340307.2.5 Veteran's Mental Health, 133340307.2.6 Child Mental Health Crisis Center, 133340307.2.7 Child Trauma Informed Care; 13340307.2.8 Mental Health Court, 133340307.2.9 Whole Health Peer Support, 133340307.2.10 Adolescent Whole Health Peer Support, 133340307.2.11 Family Partner and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions.

Relationship to Other Performing Providers' Projects in the RHP

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7. The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provides mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects:

133542405.2.2 - Austin Travis County Integral Care - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting : Mobile Crisis Outreach Team Expansion

133542405.1.3 - Austin Travis County Integral Care - Introduce, Expand, or Enhance Telemedicine/Telehealth

126844305.2.4 - Bluebonnet Trails Community Services - Design, implement, and evaluate project that provides integrated primary and behavioral health care services: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation

137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation

307459301.1.3 - Community Care Collaborative - Mobile Primary Care

137265806.2.2 - Seton Healthcare Family: University Medical Center at Brackenridge - Women's Oncology Care Screening

Plan for Learning Collaborative

Hill Country MHDD Centers will participate in a learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 287 individuals receiving mobile clinic services over the life of the project.

133340307.1.1	***1.12***	***1.12.3***	Develop and staff a number of mobile clinics that can provide access to care in very remote, inaccessible, or impoverished area of Texas	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*1133340307.3.5*	*IT-10.2*	*Activities of Daily Living (DLA-20)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Identify licenses, equipment requirements and other components needed to implement and operate operations selected Metric 1 P-2.1: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components Goal: Submission of project plan Data Source: Project Plan documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $980,876	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Hays County Mental Health Center Mobile Clinic) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 50 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $1,010,190**		**Milestone 3** P-7: Evaluate and continuously improve interventions Metric 1 P-7.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Project reports- Hill Country MHDD records Milestone 3 Estimated Incentive Payment: $ 509,525 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Hays County	**Milestone** 5 P-7: Evaluate and continuously improve interventions Metric 1 P-7.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Project reports -Hill Country MHDD records Milestone 5 Estimated Incentive Payment: $ 521,618 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Hays County

133340307.1.1	***1.12***	***1.12.3***	Develop and staff a number of mobile clinics that can provide access to care in very remote, inaccessible, or impoverished area of Texas	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*1133340307.3.5*	*IT-10.2*	*Activities of Daily Living (DLA-20)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Mental Health Center Mobile Clinic) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 100 individuals beginning service during DY4(total of 150) **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $509,524**	Mental Health Center Mobile Clinic) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 137 individuals beginning service during DY5(total of 287) **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $521,617**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $980,876	Year 3 Estimated Milestone Bundle Amount: $1,010,190		Year 4 Estimated Milestone Bundle Amount: $1,019,059	Year 5 Estimated Milestone Bundle Amount: $1,043,235
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,053,360				

St. Mark's Medical Center
Category 1 DSRIP Projects

Performing Provider Name: St. Mark's Medical Center
RHP Project Identification Number: 176692501.1.1 Pass 1
Title of Project: Expanding Access to Specialty Care

DSRIP Project Summary

Provider: St. Mark's Medical Center is a 65 bed, 100,000 square foot rural hospital, located in LaGrange, Texas, which offers inpatient, outpatient, and emergency services for a service area which primarily consists of patients from Fayette County and Lee County (combined population of 41,166) and some patients from Bastrop County (population of 74,171).

Intervention(s): This project will expand access to OB-GYN physician services by recruiting an additional OB-GYN physician. Additionally, this project will assess the viability of and develop/implement a plan to expand access to specialty care/wound care services related to cardiovascular disease and diabetes through the expansion of clinical facilities and recruitment of additional specialty physicians.

Need for the project: Between Fayette County and Lee County, there is only one OB-GYN physician, meaning that the number of OB-GYN physicians per capita is significantly lower in this area than both the Texas and United States averages. Further, cardiovascular disease and diabetes are prevalent health issues in Fayette County and Lee County, but there are currently no physicians specialized to treat cardiovascular disease and diabetes related wounds located within Lee County.

Target population: The target population is patients that require specialty OB-GYN services or other specialty care/wound care services related to cardiovascular diseases and diabetes that reside in Fayette County and Lee County. Through the recruitment of one additional OB-GYN physician, we estimate that this project will serve approximately 1920 - 2880 patients per year, as measured by the projected number of annual patient visits/encounters served by the OB-GYN physician. Through the recruitment of two additional specialty care physicians, we estimate that this project will serve approximately 960 – 1440 patients in DY4 and 1920 - 2880 patients in DY5, as measured by the projected number of additional patient visits/encounters served by the additional specialty care physicians at the for specialty/wound care clinic. Historically, approximately, 25% of the patients served by St. Mark's have been Medicaid or uninsured patients. Therefore, we expect that a similar percentage of the patients benefiting from this project will be Medicaid or uninsured.

Category 1 or 2 expected patient benefits:

- St. Mark's intends to have increased access to OB-GYN services available in the Lee County and Fayette County community by 5% over the baseline in DY4 and 10% over the baseline in DY5, as measured by the number of OB-GYN clinic hours.

- St. Mark's intends to have increased access to specialty care and/or wound care services related to cardiovascular diseases and diabetes in Fayette County and Lee County by 5% over the baseline in DY4 and 10% over the baseline in DY5, as measured by the number of specialty care clinic hours.

Category 3 outcomes: OD-6, IT 6.1: Percent improvement over baseline of patient satisfaction scores. St. Mark's intends to have increased patient satisfaction in DY4 and DY5, as measured by the results of patient satisfaction surveys inquiring whether patients are getting timely specialty care, appointments, and

information. The specific percentage improvement goals for DY4 and DY5 will be determined based on baseline patient satisfaction scores established in DY3.

Title of Project: Expanding Access to Specialty Care

Category / Project Area / Project Option: 1.9.2 – Improve access to specialty care

RHP Project Identification Number: 176692501.1.1Pass 1

Performing Provider Name: St. Mark's Medical Center

Performing Provider TPI: 176692501

Project Description

Overall Project Description

There is currently a shortage of OB-GYN physicians in Fayette County and Lee County. To address this shortage, we will expand access to specialty care physician services by recruiting an additional OB-GYN physician to provide services to patients, including low income and Medicaid patients, in Lee County and Fayette County.

Separately, patients in Fayette County and Lee County suffer from high rates of cardiovascular disease and diabetes. To help address these health issues, we will perform a GAP analysis to assess the viability of expanding access to specialty care and wound care services related to cardiovascular disease and diabetes by expanding current clinical facilities or building new clinical facilities, and recruiting additional physicians to provide these specialty services, including wound care. These measures will enable patients to receive better access to specialty care physicians and appointments. To achieve this, we will develop a Specialty Care and Wound Care Clinic implementation plan and collect baseline data for number of specialty care providers, wait times, backlog, and/or return appointments in targeted specialties to determine the level of need for specialty care in the community, as well as current specialty care capacity and productivity. This data will be used to assess the level of facilities and specialty care providers needed and establish baseline data for reporting improvement metrics used to measure the progress of the project. We will then set improvement goals for the reporting metrics for each remaining year of the Waiver and work towards achieving those goals by launching a specialty care/wound care clinic for services related to cardiovascular disease and diabetes. We will then provide these services at the clinic through contracts with specialty physicians.

This project will include the following core 1.9.2 project components:

a. Increase service availability with extended hours. We will facilitate the increase in total specialty care services hours by recruiting additional specialty care physicians in targeted specialty areas.

b. Increase number of specialty clinic locations. The specialty care physicians will be located in new and/or existing clinics operating in the community. The clinics will have space for the new physicians to provide specialty care services to patients in the community.

c. Implement transparent, standardized referrals across the system. A standardized referral system will be used to ensure that patients receive timely access to appropriate specialty care services.

d. Conduct quality improvement for project using methods such as rapid cycle improvement. St. Mark's quality improvement activities may include, but are not limited to, annual assessments of project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, key challenges associated with expansion of the project, and special considerations for safety-net populations.

The target population is patients that require specialty OB-GYN services or other specialty care/wound care services related to cardiovascular diseases and diabetes that reside in Fayette County and Lee County. Through the recruitment of one additional OB-GYN physician, we estimate that this project will serve approximately 1920 - 2880 patients per year, as measured by the projected number of annual patient visits/encounters served by the OB-GYN physician. Through the recruitment of two additional specialty care physicians, we estimate that this project will serve approximately 960 – 1440 patients in DY4 and 1920 - 2880 patients in DY5, as measured by the projected number of additional patient visits/encounters served by the additional specialty care physicians at the for specialty/wound care clinic. Historically, approximately, 25% of the patients served by St. Mark's have been Medicaid or uninsured patients. Therefore, we expect that a similar percentage of the patients benefiting from this project will be Medicaid or uninsured.

Project Goals

St. Mark's intends to have increased access to OB-GYN services available in the Lee and Fayette County community by 5% over the baseline in DY4 and 10% over the baseline in DY5, as measured by the number of OB-GYN clinic hours.

Separately, by DY5 St. Mark's also intends to have increased access to specialty care and/or wound care services related to cardiovascular diseases and diabetes in Fayette County and Lee County residents by 5% over the baseline in DY4 and 10% over the baseline in DY5, as measured by the number of specialty care clinic hours.

Challenges or Issues Faced by the Performing Provider/ How the Project Addresses those Challenges

St. Mark's expects to confront the following challenges and issues, and to address them in the following manner:

(1) Recruiting and retaining a qualified specialty care physicians who will relocate to Fayette and/or Lee County. To overcome this challenge, St. Mark's will create relocation and benefits package that will incentivize specialty care physicians to relocate to Lee and/or Fayette County.

(2) Ensuring that the new specialty care physicians have sufficient clinical space to treat patients. To overcome this challenge St. Mark's will plan to redesign or add clinical facilities that will be dedicated to the new specialty care physicians' provision of care.

How the Project is Related to RHP Goals

This project is related to the following Region 7 goals:

Goal 1: Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. By hiring additional specialty care physicians and expanding/improving clinical facilities, patients will have better access to the services they need to improve their health.

Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. By expanding access to specialty care physicians in the clinical setting, patients will be able to receive the appropriate level of care in a clinical setting, as opposed to inefficiently relying on the hospital emergency rooms for these services.

Goal 4: Bolster individual and population health by improving chronic disease management. By enhancing access to needed specialty care services , patients will be able to receive the care needed to better manage chronic diseases, such as cardiovascular diseases and diabetes, thereby improving healthcare outcomes and enabling patients to receive treatment before further complications arise.

Starting Point/Baseline

Baseline Data

We will use baseline data gathered in DY1 for the number of OB-GYN physicians and related clinic hours in Lee County and Fayette County. As of the end of DY1, there is one OB-GYN physician serving Lee and Fayette County.

During DY2, we will first perform a Gap Analysis to identify the baseline level of specialty care and wound care services capacity and the level of targeted specialty services needed in the community. This data will be used to assess the number of specialty care providers for target specialties needed and establish baseline data for reporting metrics used to measure the progress of the project. We will then use these measures to identify the level of additional need for specialty care capacity in the community, and develop and implement a plan to appropriately address this need through the recruitment of specialty care physicians and the enhancement or expansion of specialty care clinical facilities.

Time Period for Baseline

OB-GYN services – DY1.

Wound Care and other Specialty Care Services– TBD in DY2.

Rationale

Reason for Selection of Project Options and Components

Lack of access to OB-GYN physician services is a significant issue for the residents of Fayette County and Lee County. Between the two counties, there is only one OB-GYN physician, meaning that the number

of OB-GYN physicians per capita is significantly lower in this area than both the Texas and United States averages.

Cardiovascular disease (including heart disease and stroke) is the leading cause of death in Region 7. In addition, congestive heart failure represents one of the leading contributors for potentially preventable hospitalization costs in Region 7 from 2005-2010. In Lee County, 32% of all deaths are attributed to cardiovascular disease. In Fayette County, 39% of all deaths are attributed to cardiovascular disease. Additionally, rates of adult diabetes in both Lee County and Fayette County exceed the Texas state average. The rate of diabetes has been growing in both Lee and Fayette Counties in recent years and diabetic peripheral vascular disease in particular has been a common issue among this patient population. Physicians that are specialized to treat cardiovascular disease and diabetes related wounds are not located within either of the two cities in Lee County. Currently, local primary care doctors invite these specialized physicians to see patients at their clinics on a weekly or bi-monthly basis causing limited appointment availability and a limitation on the necessary medical machines needed by the specialty care provider because they cannot be transported between facilities. The need for specialized care outside of this allotted time forces residents to travel a 100 mile radius. Even with a referral to a larger city, wait times for specialty clinics at University Medical Center Brackenridge exceed six months.

As described in the project description, St. Mark's will implement each of the required project components for the "Improve Access to Specialty Care" project option included in the RHP Planning Protocol. By implementing each of these project components, St. Mark's believes that it will be able to help address the demonstrated need for specialty care services in Fayette County and Lee County.

Reason for Selection of Milestones & Metrics

We chose the milestones and metrics based on two factors: (1) which measures/metrics would best reflect the impact of our DSRIP project on the community, and (2) which measures/metrics St. Mark's has the ability to most accurately report.

Unique Community Need Identification Number

CN.2 - Inadequate access to specialty care
CN.9 - High rates of chronic disease such as: cardiovascular disease and rising rates of diabetes

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

This project represents a new initiative with regard to providing additional OB-GYN physician services and other specialty care/wound care services that are not currently available in the community.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

Not applicable.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

Outcome Measure is OD-6: Patient Satisfaction, IT-6.1, which uses adult CG-CAHPS surveys to report the percent improvement over baseline of patient satisfaction scores. Specifically, St. Mark's will be utilizing the adult CG-CAHPS survey measuring whether patients are getting timely specialty care, appointments, and information.

Reasons/Rationale for Selecting the Outcome Measure(s)

This outcome measure was selected because St. Mark's considers enhanced patient satisfaction/experience to be one of its highest priorities. This outcome measure provides a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This is the only project proposed by St Mark's Medical Center.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

N/A

List of Related Category 4 Projects *(RHP Project ID Number)*

This project ties to RD-1 (Potentially Preventable Admissions) in that expanded access to specialty care should improve the number of potentially preventable admissions into the hospital. This should happen because patients will receive earlier interventions and preventative care from specialty care physicians before issues escalate into more urgent issues. This project also ties to RD-4 (Patient Centered Healthcare) in that patient satisfaction and medication management are both directly linked with patients having regular and easy access to specialty care. This project also reinforces RD-3 (potentially preventable complications) in that increased access to specialty care, patients will be better able to receive preventive care and improve care outcomes before additional complications arise.

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

This is related to University Medical Center Brackenridge's OB Navigation Project (*137265806.2.1*), which has a similar target population for its intervention. The Central Texas Medical Center Project, Expanding Primary Care Capacity for Low-Income Residents of Hays County, TX (*121789503.1.1*) is a similar intervention. Finally, the City of Austin's Community Diabetes Project (*201320302.2.2*) works with patients who have a similar diagnosis. Other related projects include:

201320302.2.4 - City of Austin Health & Human Services Department - Prenatal & Post-natal Improvement Program

307459301.1.7 - Community Care Collaborative - Expanded Specialty Care Services at Community-Based Outpatient Settings: Pulmonology
307459301.1.6 - Community Care Collaborative - Expanded Specialty Care Services at Community-Based Outpatient Settings: GI
307459301.1.5 - Community Care Collaborative - Expanded Specialty Care Services at Community-Based Outpatient Settings: Musculoskeletal

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

St Mark's will fully participate in RHP-wide learning collaboratives for projects that directly address chronic care management. Additionally, because of the wide scope of such services and the integration of care, plans to participate in learning collaboratives regarding childhood obesity, care transitions, enhancement of interpretation services, culturally competent care, and telemedicine are expected. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers will be conducted in-person, by teleconference or electronically.

Project Valuation

Approach for Valuing Project

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

Rationale/Justification for Valuation

This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects.

176692501.1.1	***1.9.2***	**N/A**	***EXPAND ACCESS TO SPECIALTY CARE***

St. Mark's Medical Center			176692501
Related Category 3 Outcome Measure(s):	176692501.3.1	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. Conduct specialty care gap assessment based on community need Metric: P-1.1. Documentation of gap assessment. Goal: Complete needs assessment study and develop report documenting findings Data Source: Completed Needs Assessment documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $36,855 **Milestone 2**: I-22. Increase the number of specialist providers for the high impact/most impacted medical specialties Metric: I-22.1. Increase number of specialist providers in targeted specialties	**Milestone 3**: P-11. Launch/expand a specialty care/wound care clinic Metric: P-11.1. Establish/expand clinics and begin seeing patients Goal: Complete clinic expansion and begin serving clients Data Source: Documentation of new/expanded specialty care clinic and number of patients served Milestone 3 Estimated Incentive Payment: $36,855 **Milestone 4**: I-22. Increase the number of clinic hours available for	**Milestone 5**: I-22. Increase the number of specialist providers for the high impact/most impacted medical specialties Metric: I-22.1. Increase number of specialist providers in targeted specialties Goal: Hire one additional specialty care provider for specialty/wound care clinic Data Source: HR documents or other documentation demonstrating employed/contracted specialists Milestone 5 Estimated Incentive Payment: $36,855 **Milestone 6**: I-22. Increase the number of clinic hours available for the high impact/most impacted medical specialties Metric: I-22.1. Increase number of clinic hours in targeted specialties Goal: Increase OB/GYN clinic hours by	**Milestone 7**: I-22. Increase the number of specialist providers for the high impact/most impacted medical specialties Metric: I-22.1. Increase number of specialist providers in targeted specialties Goal: Hire one additional specialty care provider for specialty/wound care clinic Data Source: HR documents or other documentation demonstrating employed/contracted specialists Milestone 7 Estimated Incentive Payment: $17,500 **Milestone 8**: I-22. Increase the number of clinic hours available for the high impact/most impacted medical specialties

176692501.1.1	***1.9.2***	**N/A**	***EXPAND ACCESS TO SPECIALTY CARE***
St. Mark's Medical Center			176692501
Related Category 3 Outcome Measure(s):	176692501.3.1	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)**
Data Source: HR documents or other documentation demonstrating employed/contracted specialists Goal: Hire one additional OB/GYN provider Milestone 2 Estimated Incentive Payment: $36,855	the high impact/most impacted medical specialties Metric: I-22.1. Increase number of clinic hours in targeted specialties Goal: Increase OB/GYN clinic hours by 5% over baseline established in DY2. Data Source: Internal systems and documents demonstrating number of clinic hours Milestone 4 Estimated Incentive Payment: $36,855	5% over DY3. Data Source: Internal systems and documents demonstrating number of clinic hours Milestone 6 Estimated Incentive Payment: $36,855	Metric: I-22.1. Increase number of clinic hours in targeted specialties Goal: Increase OB/GYN clinic hours by 5% over DY4. Data Source: Internal systems and documents demonstrating number of clinic hours Milestone 8 Estimated Incentive Payment: $17,500
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 73,710	Year 3 Estimated Milestone Bundle Amount: $ 73,710	Year 4 Estimated Milestone Bundle Amount: $ 73,710	Year 5 Estimated Milestone Bundle Amount: $ 35,000

176692501.1.1	***1.9.2***	**N/A**	***EXPAND ACCESS TO SPECIALTY CARE***
St. Mark's Medical Center			176692501
Related Category 3 Outcome Measure(s):	176692501.3.1	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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 256,130			

University Medical Center Brackenridge (UMCB)
Category 1 DSRIP Projects

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Psychiatric Emergency Department
PROJECT ID: 137265806.1.1 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project intends to divert patients away from community Emergency Rooms into a more clinically appropriate and cost effective centralized Psychiatric Emergency Department.

Need for the Project: This project supports Regional goals by reducing overall health system costs incurred by patients in acute psychiatric crisis. The current system distributes patients in psychiatric crisis throughout our community emergency departments (CN.4).

Target Population: The target population for this project are patients who are currently taken to community ED's in psychiatric crisis. UMCB expects this project to serve the same ratio of indigent (37%) and Medicaid-eligible (23%) patients as it currently serves hospital-wide.

Category 1 or 2 Expected Patient Benefits: The project goal is to hire and train 45 staff members in DY3 and another 40 staff members in DY4 and 60 additional staff members in DY5. The goal for the number of patient encounters for DY3 is 2,500, 5,500 encounters in DY4, and 10,500 encounters by DY5. Cumulative total of 18,500 encounters DY3-DY5.

Category 3 Outcomes: IT3.8 Reduce the number of readmissions to performing provider's hospital system, for patients 18 years and older, for any cause, within 30 days of discharge when the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis (If an index admission has more than 1 readmission) by 5% over baseline in DY4 and 10% over baseline in DY5.

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

Category / Project Area / Project Option: **1.13.1**

RHP Project Identification Number: **137265806.1.1 Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description

This project intends to divert patients away from community Emergency Rooms into a more clinically appropriate and cost effective centralized Psychiatric Emergency Department.

This project will create a 24/7 Psychiatric Emergency Department (PED) in the region's Level I Trauma Center and safety net hospital, University Medical Center Brackenridge ("UMCB"). The PED will be licensed under the UMCB Emergency Department license. It will be located separate and apart from the main emergency department with space and staff to provide up to 6,000 per year by the end of DY5. Existing hospital space will be converted for this use and designed to create an environment that is free of architectural elements that could be used to harm oneself or others. The PED will include "observation" beds with the capacity to hold patients on involuntarily holds while awaiting an inpatient psychiatric bed. This service intends to funnel all psychiatric crisis patients, especially the under-insured and indigent population, who are currently distributed throughout our community ED's into a single point of care. Psychiatric and medical emergency services will be co-located to appropriately differentiate medical from psychiatric conditions and to address the complexity of our co-morbid population. As clinically indicated, many patients will be assessed, treated, and released back into the community. Some patients may stay in the "observation" beds while their psychiatric condition stabilizes before being transitioned to a lower level of care. Other patients may be assessed and transitioned to an inpatient psychiatric bed when one becomes available.

Project Goals and Relationship to Regional Goals:
This project supports Regional goals by reducing overall health system costs incurred by patients in acute psychiatric crisis. The current system distributes patients in psychiatric crisis throughout our community emergency departments. The patients do not have access to psychiatric assessments, and may wait for hours or days before being transferred to an inpatient psychiatric bed—regardless of the severity of the psychiatric presentation. This project proposes that all psychiatric crisis patients be funneled to a single point of service where they can be appropriately and cost effectively treated.

Project Goals:

- Increase community capacity for psychiatric crisis services, thus reducing unnecessary psychiatric admissions.

- Provide access to psychiatric crisis services to all psychiatric patients currently distributed across community emergency departments (most of which have no psychiatric coverage).
- Increase capacity for emergency medical/surgical/trauma patients in community emergency departments by diverting psychiatric patients to the new PED.

This project meets the following regional goals:

- Regional Goal #2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting; and
- Regional Goal #6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Challenges and How the Project Addresses Those Challenges:

- Renovation of existing space at UMCB to create the PED with observation beds. A committee has been formed and is developing plans for construction and renovation.
- Working with community partners (law enforcement, EMS) to divert patients in psychiatric crisis to the PED rather than the closest Emergency Department (which is the current protocol). This challenge will be addressed by two community-wide committees, which will develop and implement new crisis protocols. These committees have regular participation from community inpatient and outpatient providers, EMS, law enforcement, mental health, criminal and civil court, and patient advocacy groups.

5-Year Expected Outcome for Provider and Patients:

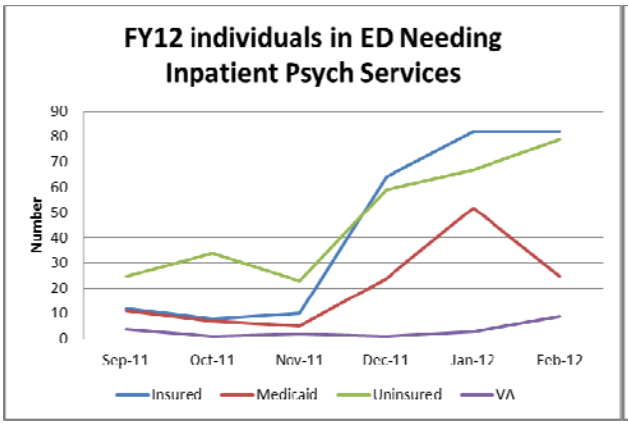
- Appropriate utilization of current psychiatric inpatient bed capacity by decreasing unnecessary admissions and readmissions for patients with behavioral health substance use disorders to decrease costs of inpatient care.
- Decrease time community emergency departments are on diversion due to the number of psychiatric patients being held in the ED
- Increase access to crisis services to the target population by providing a minimum of 10,500 encounters in clinically appropriate psychiatric emergency department.
- Community-wide cost avoidance will be demonstrated by fewer psychiatric patients in community EDs, avoidable psychiatric admissions, and the prevention of psychiatric readmissions.

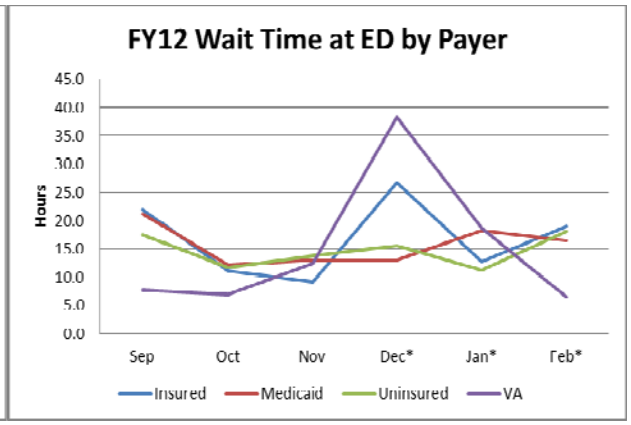
Starting Point/Baseline:

This is a new project and the baseline is zero. Staff will be hired and trained in DY3, with initial patient services to begin in DY3. Implementation of new crisis protocols will divert psychiatric patients to the PED, allowing for utilization data to be gathered and analyzed.

Rationale

As is demonstrated from the data below, mental health patients accessing community emergency inpatient rooms continue to increase. Most emergency rooms in the community have no psychiatrists or mental health providers. As a result, patients stay in emergency rooms waiting for transfer to an inpatient setting, often without receiving treatment while they wait.





The Report to Senator Kirk Watson 10in10 Initiative: Item No. 7 – Behavioral Health Services, co-authored by Central Health and Austin Travis County Integral Care in May 2012 (the "10 in 10 Report") outlines a list of recommendations, including: "A psychiatric facility co-located with the proposed re-developed University Medical Center at Brackenridge with a psychiatric emergency room." The report goes on to state: "The new psychiatric emergency room would have a separate entrance from the general emergency room. This helps to ensure privacy and dignity for individuals in crisis and minimizes discomfort for both individuals in medical crises and for individuals in psychiatric crises. A psychiatric emergency room will allow consumers in crisis 24-hour access to intake and assessment; social workers and counselors would be available to triage and divert people to the appropriate level of care based on their level of acuity, and staff with prescribing authority such as a psychiatrist or advanced nurse practitioner (APN) would be available at all times to stabilize and treat."

Currently, patients in psychiatric crisis are distributed across the community's emergency departments. Psychiatric expertise is neither available at most of the community emergency departments nor consistently available through programs of the Local Mental Health Authority. As a result, patients waste unnecessary time and resources waiting for a transfer to an inpatient psychiatric bed when, with proper psychiatric assessment, a less restrictive and less costly alternative could be identified.

With limited psychiatric crisis services available in this area, patients often spend extended amounts of time within the community's EDs. Approximately $30,000 worth of nursing time is used monthly to hold patients in need of behavioral health services in the UMCB ED until an appropriate psychiatric care setting is identified.

Project Components:

UMCB proposes to meet the following required 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.* The Travis County Healthcare District convenes a monthly meeting of key community stakeholders (city and county government, EMS, law enforcement, the Local Mental Health Authority, hospital systems—including Seton/University Medical Center Brackenridge, and inpatient behavioral health providers) called the Psychiatric Stakeholders Committee to identify gaps and propose solutions to

address those gaps. This committee will support development of crisis stabilization services. The committee has worked on a report for our local State Senator in May 2012 titled 10 in 10 Initiative: Item No. 7 – Behavioral Health Services. This report identifies key gaps in our current behavioral health system and proposed solutions, including the creation of the community Psychiatric Emergency Department.

b) *Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.* The Psychiatric Stakeholders Committee also analyzed the capacity of current community crisis stabilization services and current utilization patterns. A subcommittee has been formed and begun meeting to analyze eligibility and discharge criteria for each crisis service in the community.

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.* The Psychiatric Stakeholders Committee has done the assessment and published its finding and recommendations in the May 2012, 10 in 10 report.

d) *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Members of the Psychiatric Stakeholders Committee have researched crisis alternative service models throughout the country and some members have visited programs in other parts of the county. This information will help inform UMCB as the community PED is developed.

e) *Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* The Psychiatric Stakeholders Committee will serve as the community's learning collaborative and will share "lessons learned" with community partners and address special considerations for the behavioral health safety-net population.

Other) *Conduct Quality Improvement:* The project will undergo continuous quality improvement efforts that will include identifying project impacts, "lessons learned", opportunities to scale the project to broader populations, and challenges regarding safety net populations. These efforts will be reviewed by the Psychiatric Stakeholders Committee on a regular basis and incorporated into the project via protocols, policies, and procedures.

Unique community need identification numbers the project addresses:

- CN.4 – Inadequate access to behavioral health care
- CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues such as:
    - Prevention and supported recovery
    - Screening, outpatient treatment, and integrated care
    - Intensive outpatient, supported housing, and residential treatment
    - Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative for the region and will improve response to patients with behavioral health needs. In addition, this initiative will further the development of needed infrastructures and partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care in the community. Analysis of the current gap in services and the identification of the need for a Psychiatric Emergency Department was conducted in May 2012, however no funding existed to implement a solution.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project compliments, but does not duplicate funding other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measure(s)

- OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
- IT-3.8 Behavioral Health / Substance Abuse 30 day readmission rate

Reasons/rationale for selecting the outcome measures:
By creating a PED, the community will prevent psychiatric admissions and readmissions. Currently, patients in psychiatric crisis who are taken to a community ED lacking psychiatric providers will be automatically transferred to an inpatient psychiatric bed when one becomes available in the community. This project will lead to a reduction in readmissions because the PED will utilize the community health information exchange to reinforce continuation of the treatment plan developed during the inpatient stay, thereby reducing readmissions. To effectively utilize the data and analyze results, the process metrics outlined above must be completed.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects
There are several projects within UMCB that will supplement and support our proposal for a Psychiatric Emergency Department. Although these projects are related to PED, they each represent different access points along the continuum of psychiatric care and, therefore, are not duplicative.

List of Related Category 1 & 2 Projects

137265806.1.5 – Expand Psychiatric Residencies
137265806.1.3 – Psychiatric Telemedicine for Emergency Services
137265806.2.2 – Substance Abuse Navigation
137265806.2.3 – Behavioral Health Navigation

List of Related Category 4 Projects
RD-1. Behavioral Health and Substance Abuse Admission Rate
RD-2.3. Behavioral Health and Substance Abuse: 30-Day Readmission Rate
RD-2.7. All-Cause: 30-Day Readmission

RD-4.1. Patient Satisfaction

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Projects proposed by other providers across the Region also relate to Care Transition. These projects either 1) expand psychiatric care or 2) serve a different population.

201320302.2.1: ACT for Housing First Permanent Supportive Housing
133542405.2.1: Behavioral health clinic with integrated medical care
133542405.2.2: Expansion of mobile crisis intervention service
133542405.2.2: Telepsychiatric service via mobile crisis unit
133542405.1.2: Expand Specialty Behavioral Healthcare Prescriber
126844305.1.1: Youth counseling in schools for Fayette and Lee Counties
126844305.2.1: Transitional Housing Guided by Peer Support
126844305.2.4: BH and Primary Care Integration
126844305.2.3: Jail Diversion Project
133340307.2.2: Hays County Mental Health/Intellectual & Developmental Disability Crisis Center
133340307.2.1: Hays County Mental Health Center Integrated Care
133340307.2.4: Trauma Informed Care
133340307.2.10: Behavioral Health Training & Consultation
307459301.2.3: Integrated BH Intervention for Targeted Chronic Disease Patients
307459301.1.8: Telepsychiatry Services at Community-Based Outpatient Settings

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

UMCB will fully participate with the Psychiatric Stakeholders Committee in order to engage in continuous learning, improvement, and community outreach. The committee is made up of city and county government, law enforcement, EMS, and other local hospitals such as:

City of Austin Health & Human Services Department - 201320302
Austin Travis County Integral Care - 133542405

Project Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across

categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

This project will incur cost for operational, capital renovations, and staffing the PED 24/7 with psychiatrists, psychiatric nurses, psychiatric APNs, psychiatric social workers, and psychiatric techs. Community-wide cost avoidance will be demonstrated by fewer psychiatric patients in community EDs, avoidable psychiatric admissions, and the prevention of psychiatric readmissions.

UNIQUE IDENTIFIER: 137265806.1.1 – PASS 3	***RHP REFERENCE NUMBER: 1.13.1***	***PROJECT COMPONENT(S) 1.13.1 (A-E)***	***PROJECT TITLE: DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI: 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.4 – Pass 3*	*IT-3.8*	*Behavioral Health / Substance Abuse 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: [P-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: TBD determined through assessment and plan Goal: Identify services, staffing, to operationalize community Psychiatric Emergency Department Data Source: Written plan Milestone 1 Estimated Incentive Payment: $ 3,721,068	**Milestone 2** [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric [P-4.1]: Number of staff hired and trained. Baseline: New program with no existing staff in DY2; baseline zero Goal: 45 staff hired and trained. Data Source: Staff rosters and training records. Number of staff hired and trained. Milestone 2 Estimated Incentive Payment: $ 1,422,494 **Milestone 3** [I-X]: Evidence of improved access for patients seeking services. Metric [I-X.1] Number of encounters for target population. Baseline**:** This is a new project; baseline in DY3 is 0. Goal**:** 2,500 encounters Data Source: Claims, encounters, clinical record data Milestone 3 Estimated Incentive Payment: $1,422,494		**Milestone 5** [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric [P-4.1]: Number of staff hired and trained. Baseline: New program with no existing staff in DY2; baseline zero Goal:.40 additional staff will be hired and trained. Data Source: Staff rosters and training records Milestone 5 Estimated Incentive Payment: $ 1,121,569 **Milestone 6** [I-X]: Evidence of improved access for patients seeking services. Metric [I-X.1] Number of encounters for target population. Baseline**:** This is a new project; baseline in DY3 is 0. Goal**:** 5,500 encounters (cumulative of 8,000 encounters) Data Source: claims, encounters, clinical record data. Milestone 6 Estimated Incentive	**Milestone 9** [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric [P-4.1]: Number of staff hired and trained. Baseline: New program with no existing staff in DY2; baseline zero Goal: 60 additional staff will be hired and trained. Data Source: Staff rosters and training records Milestone 9 Estimated Incentive Payment: $ 921,346 **Milestone 10** [I-X]: Evidence of improved access for patients seeking services. Metric [I-X.1] Total number of encounters for target population. Baseline**:** New program in DY2; baseline 0. Goal**:** 10,500 encounters (cumulative of 18,500 encounters) Data Source: Claims, encounters, clinical record data.

UNIQUE IDENTIFIER: 137265806.1.1 – PASS 3	***RHP REFERENCE NUMBER: 1.13.1***	***PROJECT COMPONENT(S) 1.13.1 (A-E)***	***PROJECT TITLE: DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI: 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.4 – Pass 3*	*IT-3.8*	*Behavioral Health / Substance Abuse 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 [P-9]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment on implementing these improvements. Metric 1 [P.9-1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year. Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $ 1,422,494		Payment: $ 1,121,569 **Milestone 7** [I-12]: Utilization of appropriate crisis alternatives Metric [I-12.1]: 50% increase in utilization of appropriate crisis alternatives. Baseline: This is a new project. Baseline for DY3 is 0. Goal: Of the total people receiving psychiatric crisis services 50% will be in the appropriate setting. 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. This would be measured at specified time intervals throughout the project to determine if there was an increase. Data source: Psychiatric Stakeholders Committee quarterly metrics. Milestone 7 Estimated Incentive	Milestone 10 Estimated Incentive Payment: $ 921,346 **Milestone 11** [I-12]: Utilization of appropriate crisis alternatives Baseline: This is a new project. Baseline in DY4 is 0. Metric [I-12.1]: 50% increase in utilization of appropriate crisis alternatives. Goal: Of the total people receiving psychiatric crisis services 50% will be in the appropriate setting. 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. This would be measured at specified time intervals throughout the project to determine if there was an increase. Data source: Psychiatric Stakeholders Committee quarterly metrics. Milestone 11 Estimated Incentive Payment: $ 921,346

UNIQUE IDENTIFIER: 137265806.1.1 – PASS 3	***RHP REFERENCE NUMBER: 1.13.1***	***PROJECT COMPONENT(S) 1.13.1 (A-E)***	***PROJECT TITLE: DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI: 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.4 – Pass 3*	*IT-3.8*	*Behavioral Health / Substance Abuse 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Payment: $ 1,121,569 **Milestone 8** [P-9]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment on implementing these improvements. <u>Metric 1</u> [P.9-1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year. Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 1,121,569	**Milestone 12** [P-9]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment on implementing these improvements. <u>Metric 1</u> [P.9-1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year. Data Source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 12 Estimated Incentive Payment: $ 921,345

UNIQUE IDENTIFIER: 137265806.1.1 – PASS 3	***RHP REFERENCE NUMBER: 1.13.1***	***PROJECT COMPONENT(S) 1.13.1 (A-E)***	***PROJECT TITLE: DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI: 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.4 – Pass 3*	*IT-3.8*	*Behavioral Health / Substance Abuse 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $ 3,721,068	Year 3 Estimated Milestone Bundle Amount: $ 4,267,482		Year 4 Estimated Milestone Bundle Amount: $ 4,486,276	Year 5 Estimated Milestone Bundle Amount: $ 3,685,383
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 16,160,209				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Expand Post Graduate Training for Psychiatric Specialties/Psychiatric Residency Programs
PROJECT ID: 137265806.1.2 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project will expand residency training programs in psychiatric specialties to expand the workforce of providers in our community treating psychiatric patients and increase access to behavior health services for the indigent and uninsured.

Need for the Project: By expanding the behavioral health workforce, greater care can be provided to individuals with behavioral health needs in Travis County, especially those who are under- or un-insured. This addresses the CN.4 in the RHP 7 Plan.

Target Population: The project seeks to serve inpatients and outpatients throughout the community in need of behavioral health services by adding 14 trainees, as well as additional faculty members. Patients served include an estimated 25% indigent/uninsured and 25% Medicaid.

Category 1 or 2 Expected Patient Benefits: This project seeks to include additional residents/trainees in each program: (8) General Psychiatry Residency Program, (8) Psychosomatic Fellowship Program, and (8) Psychopharmacology Residency Program and (2) Psychology Post Docs by DY5. Additional faculty will be also added to support these trainees (3) each in DY3, DY4, and DY5. Through clinical rotations and externships, we expect residents/trainees and faculty added to provider's workforce, will result in 5,000 additional patient encounters in DY3, 7,000 encounters in DY4, and 9,000 encounters in DY5. By the end of DY5, a total of 21,000 patient encounters will occur.

Category 3 Outcomes: IT-1.18. Rate 1. Increase the number of patients served by this project who have a follow-up behavioral health appointment within 30 days of discharge from a psychiatric facility in Travis County by 5% above baseline in DY4 and 10% above baseline in DY5.

Identifying Project and Provider Information

Title of Project: **Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or localities within non-HPSA counties which do not have access equal to the rest of the county: Expand Post Graduate Training for Psychiatric Specialties/Psychiatric Residency Programs**

Category / Project Area / Project Option: **1.14.1**

RHP Project Identification Number: **137265806.1.2 Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description

Overall Project Description

This project will expand post graduate training programs in psychiatric specialties to expand the workforce of providers in our community treating psychiatric patients, and will increase behavioral health encounters by 21,000 visits by the end of this demonstration period.

The expansion of behavioral health post-graduate training positions will lead to expanded capacity to serve patients in the short and long term. Trainees will learn how to deliver integrated care and will provide psychiatric care to the community during their training and as independent practitioners at the completion of their training. Patients will be treated at Seton Healthcare hospitals, clinics, and physician clinics by residents, fellows and faculty[5]. By expanding the behavioral health workforce, greater access to care will be provided to individuals with behavioral health needs in Travis County, especially those who are Medicaid recipients, indigent or uninsured.

Beginning in DY3, the General Psychiatry Residency Program will be expanded by two residents per year; the Psychosomatic Fellowship Program will have two fellows per year; and the Psychopharmacology Residency Program will have an additional two residents per year. Moreover, over the course of the waiver a Psychology Post-Doctoral Program will be started, with two trainees enrolled. Additional faculty will be recruited to support the increased number of trainees and to provide psychiatric services to our community.

Goals and Relationship to Regional Goals:
This project will focus on the behavioral health needs of persons in Travis County, especially those on Medicaid or uninsured.

[5] Seton Medical Center Austin, University Medical Center at Brackenridge, Seton Shoal Creek Hospital, Seton Community Health Centers, and the Seton Mind Institute.

Project Goals:

- Increase the size of the post graduate training programs for psychiatric specialties and via clinical rotations and externships, increase patient encounters by 21,000
- Hire additional faculty to supervise trainees
- Expand capacity to serve patients with behavioral health needs in our community
- Develop workforce to provide care to expanded behavioral health services being developed through the waiver and other initiatives to meet community need

This project meets the following regional goals:

- Regional Goal #2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting
- Regional Goal #3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
- Regional Goal #6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Challenges or Issues Faced by the Performing Provider and How the Project Addresses those Challenges

- Ensuring faculty members are hired to supervise expanded number of trainees. With a shortage of psychiatrists and other behavioral health specialists, it can be difficult to recruit high-quality faculty[6]. Work has begun on recruiting faculty with innovative ideas to support teaching trainees to work in innovative, patient centered treatment settings.
- Identifying and matching qualified applicants into the post-graduate training programs. For the past several years, there have been growing numbers of applicants to this psychiatric training program. The number of applicants interviewed has been expanded in anticipation of bringing in more trainees.
- Obtaining accreditation for the psychology post-doctoral program. Partnerships are being developed with two universities that have psychology post-doctoral programs to begin work on the accreditation. One of these institutions (University of Texas Southwestern) has also suggested expanding their already-accredited program to cover new trainees in Austin, thus negating the need for new accreditation.

5-Year Expected Outcome for Provider and Patients:

- Increased number of psychiatrists, psychosomatic psychiatrists, psychopharmacologists, and psychologists practicing in the region
- 32 General Psychiatry Residents, 2 Psychosomatic Fellows, 3 Psychopharmacology Residents, and 2 Psychology Post-Doctoral trainees enrolled in the training programs at the completion of the waiver
- Additional faculty hired to support the training programs

[6] "Highlights: The Supply of Mental Health Professionals in Texas -2010", Texas Department of State Health Services Center for Health Statistics, E-Publication No. E25-12347. Accessed at: http://www.dshs.state.tx.us/chs/hprc/publicat.shtm).

Starting Point/Baseline

As of September 30, 2012, there were 24 General Psychiatry Residents, one Psychopharmacology Resident, no Psychosomatics Fellows, and no Psychology trainees in the Seton Healthcare Family/University Medical Center Brackenridge. Additional residents/trainees will be brought in during DY3, with additional faculty in DY4.

Rationale

The supply of behavioral health care providers is inadequate in most of the state. In April of 2011, 195 Texas counties (of 254, or 77%) held federal designations as whole county Health Provider Shortage Areas (HPSAs). This is an increase from the 183 counties designated in 2002.

Travis County gaps in behavioral healthcare identified in a join report by Central Health and Austin Travis County Integral Care are presented in the table below[7]:

Profession	Current # of Providers	Ratio of Provider per 100,000 Population	Additional Number of Providers Needed by 2030 to maintain current ratio
Psychiatrist	173	17.1	56
Psychologist	711	71.6	96
Lic Professional Counselors	1,233	122	397
Lic Chem Dependency Counselors	467	43.2	150
Social Workers	2,026	200.4	653

The report also stated that the ideal ratio of psychiatrists in a community is 25.7 psychiatrists per 100,000 of population. To meet population projections for 2030, Travis County will actually need an additional 171 psychiatrists.

In addition, by expanding training slots for psychiatric residents and fellows, psychologists, and psychopharmacologists, we are expanding the work-force of fully qualified psychiatrists and other behavioral health practitioners in our region. Approximately 70% of residency graduates practice within 50 miles of where they completed their training;[8] however, in the past two years 100% of our graduates have remained in this region to practice.

Each residency slot costs the supporting entity at least $150,000 per year. Each faculty costs the supporting entity a minimum of $300,000 per year. Residents provide care to patients under supervision of faculty. While a single resident is not as efficient as a fully-trained psychiatrist, progression through training will lead to increased efficiency and the ability to serve more patients.

[7] Report to Senator Kirk Watson 10in10 Initiative: Item No. 7 – Behavioral Health Services (the 10 in 10 Report). Central Health and Austin Travis County Integral Care. May 2012.

[8] Code Red: The Critical Condition of Health in Texas 2012. www.coderedtexas.org

Furthermore, faculty associated with the training programs provide direct service to patients in the community as well. As the training programs produce more graduates, the expansion of the number of psychiatrists and other behavioral health providers in the region will lead to increased access to outpatient mental health services, leading to fewer patients in crisis by utilizing the most expensive services.

Project Components:

This project proposes to meet the following core components:

a) *Conduct a qualitative and quantitative gap analysis to identify needed behavioral health specialty vocations lacking in the health care region and the issues contributing to the gaps.* Some initial analysis was included in the 10 in 10 report as well as within the Seton/UT Southwestern Psychiatry Department. Additional analysis specific to the requirements of this project will be completed in the first year of the project.

b) *Develop plan to remediate gaps identified and implement a data reporting mechanism to assess progress toward goal. This plan will specifically identify: 1) The severity of shortages of behavioral health specialists in a region by type (psychiatrists, licensed psychologists, nurse practitioners, physicians assistants, nurses, social workers, licensed professional counselors, licensed marriage and family therapists, licensed chemical dependency counselors, peer support specialists, community health workers etc.). 2) Recruitment targets by specialty over a specified time period. 3) Strategies for recruiting healthcare specialists. 4) Strategies for developing training for primary care providers to enhance their understanding of and competency in the delivery of behavioral health services and thereby expand their scope of practice.* The severity of shortages has been documented in the 10 in 10 report. Recruitment targets and strategies have been identified by the Seton/UT Southwestern Psychiatry Department. The Psychiatry Department is collaborating with primary care residency programs and primary care clinics to train primary care providers in the identification and treatment of psychiatric illnesses.

c) *Assess and refine strategies implemented using quantitative and qualitative data. Review the intervention(s) impact on behavioral health workforce in HPSA areas and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* This assessment and review will take place through the community collaborative called the Psychiatric Stakeholders Committee.

Unique community need identification numbers the project addresses:

- CN.4 – Inadequate access to behavioral health care
- CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues such as:
    - Prevention and support recovery
    - Screening, outpatient treatment, and integrated care
    - Intensive outpatient, supported housing, and residential treatment
    - Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care

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

This is a new initiative for the region and will improve response to patients with behavioral health needs. In addition, this initiative will further the development of needed infrastructures and

partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care in the community.

Related Activities Funded by U.S. Dept. of Health and Human Services
This project compliments, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measure(s)

OD-1 Primary Care and Chronic Disease Management
IT-1.18 Follow-Up After Hospitalization for Mental Illness

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

Reasons/rationale for selecting the outcome measures:
By expanding the behavioral health post-graduate training programs and behavioral health providers in the community, patients will have better access to outpatient behavioral health providers following an inpatient psychiatric hospitalization. This project is expected to increase the number of patients receiving a follow-up behavioral health appointment within 30 days of discharge from a psychiatric facility. Provider will track follow-up care provided at Seton Healthcare outpatient clinics[9] and Lonestar Circle of Care.

Relationship to Other RHP Projects
There are several projects within UMCB that will supplement and support our proposal for the expansion of psychiatric residencies at UMCB. Although these projects are related, they each represent different access points along the continuum of psychiatric care and, therefore, are not duplicative.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

137265806.1.6 – Psychiatric Emergency Department
137265806.1.3 – Psychiatric Telemedicine for Emergency Services
137265806.1.4 – Language Services Center
137265806.1.5 – Culturally Competent Care Training
137265806.2.2 – Substance Abuse Navigation
137265806.2.3 – Behavioral Health Navigation

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-1.3. Behavioral Health and Substance Abuse Admission Rate
RD-2.3. Behavioral Health and Substance Abuse: 30-Day Readmission Rate
RD-2.7. All-Cause: 30-Day Readmission Rate
RD-4.1. Patient Satisfaction

[9] Seton Community Health Centers, Seton Shoal Creek Hospital, and Seton Mind Institute.

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Projects proposed by other providers across the Region also relate to Care Transition. These projects either 1) expand psychiatric care or 2) serve a different population.

201320302.2.1: ACT for Housing First Permanent Supportive Housing
133542405.2.1: Behavioral health clinic with integrated medical care
133542405.2.2: Expansion of mobile crisis intervention service
133542405.2.2: Telepsychiatric service via mobile crisis unit
133542405.1.2: Expand Specialty Behavioral Healthcare Prescriber
126844305.1.1: Youth counseling in schools for Fayette and Lee Counties
126844305.2.1: Transitional Housing Guided by Peer Support
126844305.2.4: BH and Primary Care Integration
126844305.2.3: Jail Diversion Project
133340307.2.2: Hays County Mental Health/Intellectual & Developmental Disability Crisis Center
133340307.2.1: Hays County Mental Health Center Integrated Care
133340307.2.4: Trauma Informed Care
133340307.2.10: Behavioral Health Training & Consultation
307459301.2.3: Integrated BH Intervention for Targeted Chronic Disease Patients
307459301.1.8: Telepsychiatry Services at Community-Based Outpatient Settings

Project Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Project Identifier 137265806.1.2 – Pass 3	***RHP PP Reference Number: 1.14.1***	***Project Component(s): 1.14.1 (A-C)***	***Project Title: Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or in localities within non-HPSA counties which do not have access equal to the rest of the county: Expand Psychiatric Residency Programs***
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI - 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.5 – Pass 3*	*IT-1.18*	*Follow-Up After Hospitalization for Mental Illness- NQF 0576*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct gap analysis. Metric [P-1.1]: Analysis of behavioral health patient population and identification of needed behavioral health specialty vocations. Baseline/Goal: Conduct qualitative and quantitative gap analysis of behavioral health specialty vocations in region. Data Source: Written report Milestone 1 Estimated Incentive Payment: $ 1,010,698 **Milestone 2** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric: [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year.	**Milestone 3** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 3 Estimated Incentive Payment: $544,264 **Milestone** 4 [I-X]: Increase behavioral health specialty training and/or rotations : Metric: Increase the number of behavioral health care residents and/or trainees.	**Milestone 7** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 7 Estimated Incentive Payment: $726,673 **Milestone 8** [P-X]: Increase number of faculty members to supervise expanded number of residents/trainees. Metric [P-X.1]: Number of faculty hired Baseline: At DY 2, no additional faculty was needed.	**Milestone 10** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 10 Estimated Incentive Payment: $600,710 **Milestone 11** [P-X]: Increase number of faculty members to supervise expanded number of residents/trainees. Metric [P-X.1]: Number of faculty hired Baseline: At DY 2, no additional

PROJECT IDENTIFIER 137265806.1.2 – PASS 3	***RHP PP REFERENCE NUMBER: 1.14.1***	***PROJECT COMPONENT(S): 1.14.1 (A-C)***	***PROJECT TITLE: IMPLEMENT STRATEGIES DEFINED IN THE PLAN TO ENCOURAGE BEHAVIORAL HEALTH PRACTITIONERS TO SERVE MEDICALLY INDIGENT PUBLIC HEALTH CONSUMERS IN HPSA AREAS OR IN LOCALITIES WITHIN NON-HPSA COUNTIES WHICH DO NOT HAVE ACCESS EQUAL TO THE REST OF THE COUNTY: EXPAND PSYCHIATRIC RESIDENCY PROGRAMS***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.5 – Pass 3*	*IT-1.18*	*Follow-Up After Hospitalization for Mental Illness- NQF 0576*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 2 Estimated Incentive Payment: $1,010,697	Baseline: As of 9-30-12 (DY1): 24 General Psychiatry residents, 1 Psychopharmacology resident, 0 Psychosomatic fellow, 0 Psychology trainees. Goal: 2 General Psychiatry Residents , 2 Psychosomatic Fellows , and 2 Psychopharmacology Residents . Data Source: Student/trainee rotation schedule Milestone 4 Estimated Incentive Payment: $ 544,263 **Milestone 5** [P-X]: Increase number of faculty members to supervise expanded number of residents/trainees. Metric [P-X.1]: Number of faculty hired Baseline: At DY 2, no additional faculty was needed. Goal: Hire 3 additional faculty member(s). Data Source: Faculty rosters as listed in the ACGME		Goal: Hire 3 additional faculty member(s). At DY 2, no additional faculty was needed. Data Source: Faculty rosters as listed in the ACGME data base Milestone 8 Estimated Incentive Payment: $ 726,673 **Milestone 9** [I-X]: Increase the number of patients encounters by behavioral health residents or trainees during externships or residencies. Metric: Increase number of patient encounters for behavioral health related diagnosis. Baseline: As of 9-30-12 (DY1), no residents/fellows were providing patient visits; Baseline zero. Goal: 7,000 patient encounters in DY3 Data Source: Medical Records, Claims Milestone 9 Estimated Incentive	faculty was needed. Goal: Hire 3 additional faculty member(s). Data Source: Faculty rosters as listed in the ACGME data base Milestone 11 Estimated Incentive Payment: $ 600,710 **Milestone 12** [I-X]: Increase the number of patients encounters by behavioral health residents or trainees during externships or residencies. Metric: Increase number of patient encounters for behavioral health related diagnosis. Baseline: As of 9-30-12 (DY1), no residents/fellows were providing patient visits; Baseline zero. Goal: 9,000 patient encounters in DY3 Data Source: Medical Records, Claims

Project Identifier 137265806.1.2 – Pass 3	***RHP PP Reference Number: 1.14.1***	***Project Component(s): 1.14.1 (A-C)***	***Project Title: Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or in localities within non-HPSA counties which do not have access equal to the rest of the county: Expand Psychiatric Residency Programs***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.5 – Pass 3*	*IT-1.18*	*Follow-Up After Hospitalization for Mental Illness- NQF 0576*	
Year 2 (10/1/2012 – 9/30/2013)	**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 base Milestone 5 Estimated Incentive Payment: $ 544,263 **Milestone 6** [I-X]: Increase the number of patients encounters by behavioral health residents or trainees during externships or residencies. Metric: Increase number of patient encounters for behavioral health related diagnosis. Baseline: As of 9-30-12 (DY1), no residents/fellows were providing patient visits; Baseline zero. Goal: 5,000 patient encounters in DY3 Data Source: Medical Records, Claims Milestone 6 Estimated Incentive Payment: $544,263		Payment: $726,672	Milestone 12 Estimated Incentive Payment: $600,709

PROJECT IDENTIFIER 137265806.1.2 – PASS 3	***RHP PP REFERENCE NUMBER: 1.14.1***	***PROJECT COMPONENT(S): 1.14.1 (A-C)***	***PROJECT TITLE: IMPLEMENT STRATEGIES DEFINED IN THE PLAN TO ENCOURAGE BEHAVIORAL HEALTH PRACTITIONERS TO SERVE MEDICALLY INDIGENT PUBLIC HEALTH CONSUMERS IN HPSA AREAS OR IN LOCALITIES WITHIN NON-HPSA COUNTIES WHICH DO NOT HAVE ACCESS EQUAL TO THE REST OF THE COUNTY: EXPAND PSYCHIATRIC RESIDENCY PROGRAMS***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.5 – Pass 3*	*IT-1.18*	*Follow-Up After Hospitalization for Mental Illness- NQF 0576*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount*:* $2,021,395	Year 3 Estimated Milestone Bundle Amount: $2,177,053		Year 4 Estimated Milestone Bundle Amount: $2,180,018	Year 5 Estimated Milestone Bundle Amount: $1,802,129
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $8,180,595				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Psychiatric Telemedicine
PROJECT ID: 137265806.1.3 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project will expand access to provide 24/7 psychiatric consultations at the UMCB Emergency Department (ED) by utilizing after-hours telemedicine services.

Need for the Project: Typically, patients in psychiatric crisis presenting after-hours to the UMCB ED wait until the next day for appropriate psychiatric assessment. Through implementation of telemedicine, patients will receive a timely assessment, leading to earlier disposition at a less intense (and costly) level of care (CN.4).

Target Population: This project's targeted population is patients with a primary or secondary mental health diagnosis (including substance abuse) who present to the UMCB ED afterhours. Estimated population to be reached includes 50% uninsured and 10% Medicaid.

Category 1 or 2 Expected Patient Benefits: This project will increase access to psychiatric consultations by providing 503 consultations in DY2, 553 in DY3, 603 in DY4 and DY5 in 703. Consumer, peer and provider surveys will be utilized to indicate satisfaction with telemedicine services. Total consultations provided 2362 (DY2-DY5)

Category 3 Outcomes: IT-3.8 – The goal of this project is to reduce the 30 day readmission rate for by 10% below baseline in DY4 and a reduced readmission rate by 20% below baseline in DY5.

Title of Project: **Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers: Psychiatric telemedicine for emergency services**

Category / Project Area / Project Option: **1.11.2**

RHP Project Identification Number: **137265806.1.3 Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description

Overall Project Description

This project will expand access to after-hours psychiatric consultation in the UMCB Emergency Department by utilizing after-hours telemedicine services.

This project will provide 24/7 access to psychiatric services at the region's Level I Trauma Center/safety net hospital, alleviating the need for greater after-hours psychiatric consultations. All patients who present to the emergency department with a primary or secondary mental health diagnosis will be assessed by a psychiatrist via telemedicine for initiation of treatment and referral to the most appropriate level of care for on-going treatment.

Many of the chronically mentally ill of the Region utilize UMCB for their medical and surgical care, increasing the need for psychiatric consultation at UMCB compared to other hospitals in our region. Furthermore, many patients, especially those who are un-funded and under-funded, use UMCB's ED for treatment of psychiatric crisis. UMCB's central location establishes it as the primary location for law enforcement to bring patients needing intervention for psychiatric crisis. Because many patients cannot access routine outpatient care, they often present to emergency rooms or other crisis services (EMS, law enforcement) as their entry into the mental health system. This is especially true for those who have no mental health insurance coverage. In Travis County, mental health deputies routinely deliver psychiatric patients in crisis to the ED. Many patients remain in emergency rooms, without treatment, while awaiting transfer to a psychiatric inpatient bed. Furthermore, the shortage of psychiatrists in the area limits the after-hours availability of psychiatric consultation.

Goals and Relationship to Regional Goals:
Primarily, the focus of this project is to reduce overall health system costs incurred by patients in acute psychiatric crisis. Typically, patients in psychiatric crisis presenting after-hours to the UMCB ED will wait until the next day for appropriate psychiatric assessment. Through implementation of telemedicine, patients will receive a timely assessment, leading to earlier disposition at a less intense (and costly) level of care.

Project Goals:

- Increase patients' timely access to psychiatric care
- Decrease length of stay for psychiatric patients in the UMCB ED

- Increase community capacity for psychiatric crisis services by reducing unnecessary psychiatric admissions
- Reduce the readmission rate for patients who are served by this project.

This project meets the following regional goals:

- Regional Goal #2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting; and
- Regional Goal #6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Challenges:

- Obtaining telemedicine equipment. Equipment purchase has been finalized. Work is progressing on integrating the technology between the Seton/UMCB Information Systems Department and the Houston telemedicine group providing the services. Staff is working through firewalls to allow the systems to interface with each other.
- Some physicians resist the use of telemedicine technology. To overcome this challenge numerous in-services have been conducted and physician meetings have been organized to enhance the understanding of this technology. The number of eligible patients being served by telemedicine is trending up in a positive direction at the present time.

5-Year Expected Outcome for Provider and Patients:

- All patients who present to UMCB ED with a primary mental health diagnosis will receive a psychiatric assessment and treatment/referral as appropriate
- Appropriate utilization of current psychiatric inpatient bed capacity by eliminating unnecessary admissions
- Train ED physicians and social workers on use of psychiatric telemedicine consultation.
- Increased access to psychiatric crisis services
- Reduce the readmission rate for patients who are served by this project
- Reduce community healthcare costs for patients in psychiatric crisis

Starting Point/Baseline:

At the start of pilot project, no patients presenting to the UMCB Emergency Department had access to after-hours psychiatric consultation. By the end of the 6-month pilot program 9/30/12 138 psychiatric consultations were provided via telemedicine.

Rationale:

The following table illustrates the rising use of the emergency rooms for patients in mental health crisis. The length of time patients spend waiting to transfer to a psychiatric facility has also increased. Most emergency rooms in the community have no psychiatrists or mental health providers. As a result, patients stay in emergency rooms while awaiting transfer to an inpatient setting, often without receiving treatment while they wait.

Number of Individuals in UMCB ED Needing Inpatient Psychiatric Services (monthly)			**Wait Time for Psychiatric Inpatient Bed in UMCB ED (hours)**	
Payer	FY11 Avg	FY12	FY11 Avg	FY12

Insured	11	11	13.1	16.3
Medicaid	7	9	10.3	15.5
Uninsured	24	27	12.1	13.9
VA	2	2	9.6	16.8

There is a shortage of behavioral health providers nationally and in this region. The ideal ratio of psychiatrists in a community is 25.7 psychiatrists per 100,000 population; Travis County currently has 17.1 psychiatrists per 100,000 population.

As of March 31, 2012, there were no telepsychiatry services available for patients at UMCB; patients seen in the UMCB ED had no access to a psychiatric consultation. The patients were seen by an Emergency Medicine physician for medical clearance, and referred to a psychiatric facility with an open bed (the waiting time for a bed may be several days in our community). Upon presentation to the psychiatric facility, the patient would be seen by a psychiatrist for the first time during this crisis. That assessment may lead to an inpatient hospital stay in the psychiatric hospital or referral to a different level of care.

Project Components:

The following required core components will be included and satisfied during the course of this project:

a) *Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.* Protocols will be completed and made available to staff as appropriate for this project.

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.* An initial pilot project was conducted and provided significant data that will be used to develop processes and procedures and operational protocols.

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.* By contracting with a group that provides telemedicine psychiatric services, there is no need to identify and train behavioral health providers to provide this service.

d) *Identify modifiers needed to track encounters performed via telehealth technology.* Encounters will be tracked through billing data submitted by the telemedicine company.

e) *Develop and implement data collection and reporting standards for electronically delivered services.* Sources of data will include billing data from the telemedicine provider as well as data from the electronic health record and financial systems to determine the length of stay and total costs for patients receiving these 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.* This work will occur as part of a community collaborative (called the Psychiatric Stakeholders Committee) focused on addressing the challenges of caring for patients in psychiatric crisis in our community.

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.* This work will occur through the Psychiatric Stakeholders Committee.

h) *Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions).* This work will occur through the community dashboard presented at the Psychiatric Stakeholders Committee meetings.

Other) *Conduct quality improvement:* The project will undergo continuous quality improvement efforts that will include identifying project impacts, "lessons learned", opportunities to scale the project to broader populations, and challenges regarding safety net populations. These efforts will be reviewed by the Psychiatric Stakeholders Committee on a regular basis and incorporated into the project via protocols, policies, and procedures.

Unique community need identification numbers the project addresses:

- CN.4 – Inadequate access to behavioral health care
- CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues such as:
    - Prevention and supported recovery
    - Screening, outpatient treatment, and integrated care
    - Intensive outpatient, supported housing, and residential treatment
    - Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care
- CN.7 – Lack of coordination of care across:
    - Settings of care
    - Multiple conditions
    - Physical and behavioral health

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

This is based on a pilot that began in April 2012 (DY1), to improve response to patients with behavioral health needs. In addition, this initiative will further the development of needed infrastructures and partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care in the community.

Related Activities Funded by U.S. Dept. of Health and Human Services.

This project compliments, but does not duplicate funding other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate

Reasons/rationale for selecting the outcome measures

This project will lead to a reduction in readmissions because psychiatric patients are assessed to determine the appropriate level of care rather than being transferred into a psychiatric bed as soon as one is available in the community. Most patients recently discharged from an inpatient psychiatric admission can be effectively managed in a less restrictive setting if adequate access to psychiatric care exists. A readmission is a negative experience for the patient, resulting in missed work and lower quality of life. It increases the per capita costs of care, and does nothing to improve the health of the general population. A reduction in behavioral health-related admissions for participating inpatients will be a clear sign of this project's effectiveness.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

There are several projects within UMCB that will supplement and support our proposal for a Psychiatric Telemedicine. Although these projects are related, they each represent different access points along the continuum of psychiatric care and, therefore, are not duplicative.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

137265806.1.5 – Expand Psychiatric Residencies
137265806.1.6 – Psychiatric Emergency Department
137265806.2.2 – Substance Abuse Navigation
137265806.2.3 – Behavioral Health Navigation

List of Related Category 4 Projects

RD-1. Behavioral Health and Substance Abuse Admission Rate
RD-2.3. Behavioral Health and Substance Abuse: 30-Day Readmission Rate
RD-2.7. All-Cause: 30-Day Readmission
RD-4.1. Patient Satisfaction
RD-5.1 Admit Decision Time to ED Departure Time for Admitted Patients

Relationship to other Projects:

Projects proposed by other providers across the Region also relate to Care Transition. These projects either 1) expand psychiatric care or 2) serve a different population.

201320302.2.1: ACT for Housing First Permanent Supportive Housing
133542405.2.1: Behavioral health clinic with integrated medical care
133542405.2.2: Expansion of mobile crisis intervention service
133542405.2.2: Telepsychiatric service via mobile crisis unit
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126844305.2.4: BH and Primary Care Integration
126844305.2.3: Jail Diversion Project
133340307.2.2: Hays County Mental Health/Intellectual & Developmental Disability Crisis Center
133340307.2.1: Hays County Mental Health Center Integrated Care
133340307.2.4: Trauma Informed Care
133340307.2.10: Behavioral Health Training & Consultation
307459301.2.3: Integrated BH Intervention for Targeted Chronic Disease Patients
307459301.1.8: Telepsychiatry Services at Community-Based Outpatient Settings

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

The performing provider will fully participate in RHP-wide learning collaboratives for projects that directly address increasing access to psychiatric crisis care. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead

to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically. In this instance, collaborative providers include:

Project Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Unique Identifier: 137265806.1.3 – Pass 3	**RHP PP Reference Number: 1.11.2**	***Project Components:* 1.11.2 (A-H)**	***Project Title: Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers: Psychiatric telemedicine for emergency services***
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI - 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.6 – Pass 3*	*IT – 3.8*	*Behavioral Health/Substance Abuse Disorder 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-8]: Training for providers/peers on use of equipment/software. Metric [P-8.1]: Documentation of completions of training on use of equipment/software. Baseline: This is an expansion of a pilot program; as of the end of DY1, no provider training had been completed; baseline is zero. Goal: Train all UMCB social workers and Emergency Medicine physicians on the availability and use of psychiatric telemedicine consultation. Data Source: Training roster **Milestone 1 Estimated Incentive Payment: $ 475,010** **Milestone 2** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service Metric [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles	**Milestone 4** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service Metric [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. Baseline/Goal: Conduct monthly plan, do, act quality improvement cycles to evaluate and improvement telemedicine service. Data Source: Project plan; quality improvement reports and metrics. **Milestone 4 Estimated Incentive Payment: $ 511,588** **Milestone 5** [I-15]: Satisfaction with telemental services Metric 1 [I-15.1]: Increase telemedicine satisfaction scores of consumer, peer and provider surveys indicate satisfaction with telemedicine services Numerator: Number of patients, peers and provider surveys reporting satisfaction	**Milestone 7** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service Metric [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles Baseline/Goal: Conduct monthly plan, do, act quality improvement cycles to evaluate and improvement telemedicine service. Data Source: Project plan; quality improvement reports and metrics. **Milestone 7 Estimated Incentive Payment: $ 512,285** **Milestone 8** [I-15]: Satisfaction with telemental services Metric 1 [I-15.1]: Increase telemedicine satisfaction scores of consumer, peer and provider surveys indicate satisfaction with telemedicine services Numerator: Number of patients, peers and provider surveys reporting satisfaction	**Milestone 10** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service Metric [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. Baseline/Goal: Conduct monthly plan, do, act quality improvement cycles to evaluate and improvement telemedicine service Data Source: Project plan; quality improvement reports and metrics. **Milestone 10 Estimated Incentive Payment: $ 423,484** **Milestone 11** [I-15]: Satisfaction with telemental services Metric 1 [I-15.1]: Increase telemedicine satisfaction scores of consumer, peer and provider surveys indicate satisfaction with telemedicine services Numerator: Number of patients, peers and provider surveys reporting satisfaction

UNIQUE IDENTIFIER: 137265806.1.3 – PASS 3	RHP PP REFERENCE NUMBER: 1.11.2	*PROJECT COMPONENTS:* 1.11.2 (A-H)	*PROJECT TITLE: IMPLEMENT TECHNOLOGY-ASSISTED BEHAVIORAL HEALTH SERVICES FROM PSYCHOLOGISTS, PSYCHIATRISTS, SUBSTANCE ABUSE COUNSELORS, PEERS AND OTHER QUALIFIED PROVIDERS: PSYCHIATRIC TELEMEDICINE FOR EMERGENCY SERVICES*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.6 – Pass 3*	*IT – 3.8*	*Behavioral Health/Substance Abuse Disorder 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)**
Baseline/Goal: Conduct quarterly plan, do, act quality improvement cycles to evaluate and improvement telemedicine service. Data Source: Project plan; quality improvement reports and metrics. **Milestone 2 Estimated Incentive Payment: $ 475,090** **Milestone 3** [I-X]: Increase access to psychiatric telemedicine for ED patients Metric 1 [I-X.1]: Number of psychiatric consultations delivered via telemedicine Baseline: 6-month pilot program in DY1 provided 138 psychiatric consultations. Goal: 503 psychiatric consultations delivered via telemedicine Data Source: Patient records; consultation invoices/logs. **Milestone 3 Estimated Incentive Payment: $475,009**	Denominator: Number of patients, peers and providers surveyed. Baseline: At the end of DY2, no satisfaction survey conducted; baseline is zero. Goal: Determine baseline. Data Source: Satisfaction survey results. **Milestone 5 Estimated Incentive Payment: $ 511,587** **Milestone 6** [I-X]: Increase access to psychiatric telemedicine for ED patients Metric 1 [I-X.1]: Number of psychiatric consultations delivered via telemedicine Baseline: 6-month pilot program in DY1 provided 138 psychiatric consultations. Goal: 553 psychiatric consultations delivered via telemedicine Data Source: Patient records; consultation invoices/logs. **Milestone 6 Estimated Incentive Payment: $511,587**		Denominator: Number of patients, peers and providers surveyed. Baseline: At the end of DY2, no satisfaction survey conducted; baseline is zero. Goal: Increase telemedicince satisfactions scores by 40% over baseline. Data Source: Satisfaction survey results. **Milestone 8 Estimated Incentive Payment: $ 512,284** **Milestone 9** [I-X]: Increase access to psychiatric telemedicine for ED patients Metric 1 [I-X.1]: Number of psychiatric consultations delivered via telemedicine Baseline: 6-month pilot program in DY1 provided 138 psychiatric consultations. Goal: 603 psychiatric consultations delivered via telemedicine Data Source: Patient records; consultation invoices/logs. **Milestone 9 Estimated Incentive**	Denominator: Number of patients, peers and providers surveyed Baseline: At the end of DY2, no satisfaction survey conducted; baseline is zero. Goal: Increase telemedicince satisfactions scores by 50% over baseline Data Source: Satisfaction survey results. **Milestone 11 Estimated Incentive Payment: $ 423,484** **Milestone 12** [I-X]: Increase access to psychiatric telemedicine for ED patients Metric 1 [I-X.1]: Number of psychiatric consultations delivered via telemedicine Goal: 703 psychiatric consultations delivered via telemedicine Data Source: Patient records; consultation invoices/logs. **Milestone 12 Estimated Incentive Payment: $423,483**

UNIQUE IDENTIFIER: 137265806.1.3 – PASS 3	**RHP PP REFERENCE NUMBER: 1.11.2**	***PROJECT COMPONENTS:*** **1.11.2 (A-H)**	***PROJECT TITLE: IMPLEMENT TECHNOLOGY-ASSISTED BEHAVIORAL HEALTH SERVICES FROM PSYCHOLOGISTS, PSYCHIATRISTS, SUBSTANCE ABUSE COUNSELORS, PEERS AND OTHER QUALIFIED PROVIDERS: PSYCHIATRIC TELEMEDICINE FOR EMERGENCY SERVICES***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.6 – Pass 3*	*IT – 3.8*	*Behavioral Health/Substance Abuse Disorder 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)**
			Payment: $512,284	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,425,028	Year 3 Estimated Milestone Bundle Amount: $1,534,762		Year 4 Estimated Milestone Bundle Amount: $1,536,853	Year 5 Estimated Milestone Bundle Amount: $1,270,451
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $5,767,094				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Language Services Resource Center
PROJECT ID: 137265806.1.4 PASS 3

Provider: UMCB is a 399-bed acute care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This is a new project that will centralize interpretation and translation services and increase the number of professional, healthcare interpreters for patients with Limited English Proficiencies. This intervention is expected to increase the quality of communications between the healthcare provider and patient to achieve greater patient involvement in shared decision-making.

Need for the Project: The increasing diversity of RHP Region 7 is exacerbating the existing racial and ethnic disparities across many health conditions (CN.17). The current need for interpretation services appears to exceed provider's capacity; a gap analysis in DY2 will identify the need and workforce requirements.

Target Population: The target population will initially be Spanish-speaking patients with LEP (22% of all patient visits) at UMCB. In later demonstration years, the population will include Spanish-speaking LEP patients at other Seton hospitals in Travis County; in later years it will be expanded to include interpreters for Vietnamese-speaking LEP patients and potentially for patients who are hearing impaired. UMCB expects this project to serve the same ratio of indigent persons (37%) and Medicaid patients (23%) as it currently serves.

Category 1 or 2 Expected Patient Benefits: This project seeks to improve language access for Spanish-speaking patients with LEP by increasing the number of patient encounters with qualified healthcare interpreters. In DY4, the average number of patient encounters will be 2,800 per month. In DY5, the monthly average will be 3,010. Cumulatively (DY2-DY5), this project will provide 64,720 language encounters to predominately indigent persons and Medicaid recipients.

Category 3 Outcomes: [IT-11.6] Other Outcome Improvement Target. The percent of LEP patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters from bilingual providers and bilingual workers/employees assessed for language proficiency will increase by 3% in DY4 and by 5% in DY5 over baseline to be determined in DY3.

Title of Project: **Expand access to written and oral interpretation services: Language Services Resource Center**

Category / Project Area / Project Option: **1.4.1**

RHP Project Identification Number: **137265806.1.4 PASS 3**

Performing Provider Name: University Medical Center at Brackenridge (UMCB)

Performing Provider TPI: 137265806

Project Description

This project will increase and improve language access to Spanish-speaking patients with Limited English Proficiencies (LEP) by increasing the number of qualified health care interpreters and creating a Language Resources Center that will coordinate and optimize the delivery of interpretation services.

This project will increase the workforce of qualified health care interpreters who have specialized skills to translate oral and written communications between patients, family members, and health care providers to reduce negative impacts of communication differences. Interpretation services will be delivered in a variety of means including: face-to-face communications, telephone~~,~~ and video interpretations and written translations. This project will initially target Spanish-speaking patients with LEP at UMCB and in later years will spread to three other hospitals operated by Seton Family of Hospitals (Seton) in Travis County[10]. In later years it will be expanded to include interpreters for Vietnamese-speaking LEP patients, and potentially for patients who are hearing impaired.

Goals and Relationship to Regional Goals:
Communications in the patient's primary language are expected to increase the likelihood of safe and efficient care, open communication, adherence to treatment protocols, better health outcomes, increased patient satisfaction, lower patient days in the hospitals, reduction of readmission within 30 days, and increased patient involvement in shared decision-making.

Project Goals:
Over the life of the project, the performing provider will:

- Conduct an analysis to determine gaps in language access in DY2.
- Implement language access policies and procedures, if needed in DY3.
- Create a baseline and improve interpreter encounters per month which is the current industry standard for how to measure language access in DY4.
- Continue to measure interpreter encounters per month in DY5.
- Measure the impact of "patient's involvement in shared decision making" in the HCAPHS survey in DY4 and DY5.

[10] Seton Northwest Hospital (SNW) an acute care hospital with 124 beds; Seton Southwest Hospital (SSW) an acute care hospital with 33 beds); and Seton Medical Center Austin (SMCA) an acute care hospital with 474 beds

- Expand and consolidate services to patients of other hospitals operated by Seton Family of Hospitals (Seton Medical Center Austin, Seton Southwest Hospital and Seton Northwest Hospital).

This project meets the following regional goals:

- Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. (RHP Goal #2)
- Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. (RHP Goal #3)
- Improve the patient experience of care by increasing the quality of care and patient safety. (RHP Goal #7)

Challenges:

Consolidating current language access services under one hospital-wide structure is one of the initial challenges to the project's implementation and also a vital key component to its overall success. *Remedy:* The provider will need to appoint a leader to oversee Language Services who will identify all professional Spanish Medical Interpreter staff. The leader will need to submit an implementation plan for consolidating staff including: (1) an organizational chart and any possible supervisor and manager roles; (2) a communication plan to ensure the organization understands the changes and processes; (3) a review of all staff to assess a needs gap for additional skills sets needed by the interpretation team; and (4) an overall expectation of interpretation staff in terms of accountability measures and baseline information.

Changing medical staff behavior to document preferred language in the electronic medical record is another area of potential challenges to the success of the project. *Remedy:* The provider will work with Medical staff leadership for buy in and support. The provider has individual medical staff support in terms of research needs to ensure standardization of race, ethnicity, and preferred language in the electronic medical record. However, the provider will also create a brief training highlighting both the benefits and how their support is critical to helping reduce health disparities.

5-Year Expected Outcome for Provider and Patients:

This project will further the development of needed infrastructures and partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care to LEP patients. By the end of the project, 64,720 language encounters with qualified health care interpreters will be provided. This project will increase the percent of LEP patients receiving both an initial assessment and discharge instructions by trained bilingual providers and employees. By providing access to written and oral interpretation services, the expected outcome is a patient experience where patient safety, medical error and the ability to understand treatment options are improved.

Starting Point/Baseline:

The delivery of current interpretation services at UMCB and other Seton hospitals is currently decentralized, without common policies and procedures. The creation of the LARC is a new approach to the delivery of services and will begin with the identification of gaps in language access. This is a new program; baseline is zero. In DY3 the performing provider will implement language access policies and procedures, if needed, and increase capacity of qualified healthcare interpreters. .

Rationale:
The need for this project is based on data in the *RHP #7 Community Needs Assessment, Full Report, July 2012*. The percent of people over five (5) years of age who speak a language other than English at home varies widely across the region, from 18.3% in Fayette County to approximately 32% in Travis and Caldwell counties.

According to the Texas State Data Center Population Projections, Region 7 is projected to become increasingly diverse through 2016, with the greatest increases attributed to Hispanics (increasing from 34% of the region in 2010 to approximately 41% in 2016). Hispanics typically have higher rates of diabetes, obesity, and physical inactivity compared with Whites. In addition, Hispanic mothers also have higher rates of teen births and lower rates of timely prenatal care than White mothers. Conversely, mortality rates for cardiovascular disease, cancer, and HIV/AIDS tend to be lower among Hispanics. A more diverse population will continue to increase the need for culturally sensitive and linguistically accessible prevention and care.

The Institute of Medicine report, *Unequal Treatment*, suggests a link between improved communication and improved patient health status through improved patient satisfaction and adherence. (Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care.* Washington, DC: The National Academies Press; 2002)

The 2011 National Healthcare Disparities Report by the Agency for Healthcare Research and Quality (AHRQ) concludes that translation and interpretation services facilitate communication between the provider and the patient. The report includes about 250 health care measures that show persistent challenges in access to care faced by many racial and ethnic groups. Forty percent (40%) of the measures showed disparities getting worse between the years 2002 and 2008. In particular, Latinos, Alaska Natives and American Indians experienced worse access than Whites on more than 60% of the access measures, while African American experienced worse access on more than 30% of the access measures. (Chapter 9, pages 219-230.) This report also refers to finding from the Institute of Medicine that has identified patient centeredness as a core component of quality health care. Patient centeredness is defined as: [H]ealth care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care."

Project Components:
The UMCB Language Services Resources Center project will address all of the required core components as follows:

a. *Identify and address language access needs and/or gaps in language access.* The performing provider will engage language service vendors to provide a language assessment report for UMCB, and will undertake an internal audit of language access services to identify needs and gaps. The provider will also report to senior leaders the lessons learned and key challenges with expansion including special considerations for safety-net populations. Finally, the provider will also establish an annual Language Services Summit for interpretation and translation vendors and staff regarding skills training including process improvements.

b. *Implement language services policies and procedures (in coordination with statewide and federal policies to ensure consistency across the state).* The provider will review Texas Department of State Health Services (DSHS) policies, United States Department of Health and Human Services (HHS) Office of Civil Rights policies, and The Joint Commission Cultural Competence Module requirements. The review will allow UMCB to draft and implement language services policies and procedures, if needed.
c. *Increase training to patients and providers at all levels of the organization (and organization wide) related to language access.* The provider will assess the current "Notice of Language Services" provided to patients and create awareness training of language services to providers at all levels of the organization.
d. *Increase interpretation staff.* The provider will assess the current service levels of interpretation and translation services and compare to community and organization needs. Possible options include but are not limited to increased telephone interpretation awareness, video interpretation feasibility, and hiring of additional staff for language needs.
e. *(Other) Conduct quality improvements:* The project will undergo continuous quality improvement efforts that will include identifying project impacts, "lessons learned", opportunities to scale the project to broader populations, and challenges regarding safety net populations. These efforts will be incorporated into the project via policies and procedures on a regular basis and shared throughout Seton Healthcare Family of Hospitals.

Unique community need identification numbers the project addresses:
CN.17 Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions.

How the project represents a new initiative or significantly enhances and existing delivery system reform initiative:
This project expands and reforms an existing but fragmented language services delivery system at UMCB by centralizing the delivery of services and expanding the health care interpreter workforce. Centralizing and coordinating the delivery of interpretations permits a continuity of communication between interpreters, providers and patient and is expected to impact positive health outcomes. In later years, the coordinated delivery of qualified health interpretation services will also be expanded to other Seton Healthcare Family hospitals in Travis County.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measure:
OD 11 Addressing Health Disparities in Minority Populations
IT-11.6 Other Outcome Improvement Target

The percent of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and

bilingual workers/employees assessed for language proficiency. NQMC:005611 [11]

Reasons/rational for selecting the outcome measures:
Interpreter services are frequently provided by untrained individuals, or individuals who have not been assessed for their language proficiency, including family members, friends, and other hospital employees. Research has demonstrated that the likely results of using untrained interpreters or friends, family, and associates are an increase in medical errors, poorer patient-provider communication, and poorer follow-up and adherence to clinical instructions. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or from bilingual employees who are trained and assessed for language and interpretation proficiency during critical times in a patient's health care experience.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects
This project is directly related to UMCB's Culturally Competent Care Training project through their mutual goals. This project also supports all other hospital-based projects of the Performing Provider that serve Spanish-speaking patients with LEP.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*
137265806.1.5: Culturally Competent Care Training

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-2.7 All-Cause: 30-Day Readmission
RD-4.1. Patient Satisfaction
RD-4.2. Medication Management

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects
No other regional performing providers are establishing projects that provide written and oral interpretation. Provider will reach out to other performing providers across the state who are establishing similar projects to share learnings, identify challenges and discuss solutions, and address special considerations for serving the safety net population.

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

[11] Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute http://qualitymeasures.ahrq.gov/content.aspx?id=27296

The performing provider will fully participate in a RHP-wide learning collaborative for projects which directly address improving healthcare services of Spanish-speaking patients with LEP. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference, or electronically.

Project Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. This transformational delivery of interpretation services will result in better health outcomes, increased patient satisfaction, appropriate utilization of services and reduced cost of services.

UNIQUE IDENTIFIER: 137265806.1.4 – PASS 3	RHP PP REFERENCE NUMBER: 1.4.1	PROJECT COMPONENTS: 1.4.1 (A-D)	PROJECT TITLE: EXPAND ACCESS TO WRITTEN AND ORAL INTERPRETATION SERVICES: LANGUAGE SERVICES RESOURCE CENTER
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.7 – Pass 3*	*IT-11.6*	*Other Outcome Improvement Target*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct an analysis to determine gaps in language access. **Metric** [P-1.1]: Gap Analysis **Goal:** Produce a gap analysis report **Data Source**: Gap Analysis, Business intelligence/ Program Records **Milestone 1 Estimated Incentive Payment: $2,881,622**	**Milestone 3** [P-3]: Implement language access policies and procedures. policies and procedures **Baseline/Goal:** Develop and implement hospital-wide language services policies and procedures **Data Source:** Performing Provider policies and procedures **Milestone 3: Estimated Incentive Payment: $1,551,761** _____ **Milestone 4** [P-5]:Train/certify additional health care interpreters **Metric** [P-5.1]: Expand capacity of qualified health care interpretation workforce. **Baseline:** This is a new project; baseline at DY2 is zero. **Goal:** Train 60 staff members to serve as Spanish Bilingual Assistants **Data Source:** HR workforce training data, Program materials **Milestone 4 Estimated Incentive Payment: $1,551,760**	**Milestone 6** [I-13]: Improve language access **Metric** [I-13.1]: The number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year. **Baseline:** This is a new project; baseline at DY2 is zero. **Goal:** Perform a monthly average of 2800 qualified language interpreter encounters. **Data Source:** Program data and reports **Milestone 6 Estimated Incentive Payment: $ 1,553,874** **Milestone 7** [P-5]:Train/certify additional health care interpreters **Metric** [P-5.1]: Expand capacity of qualified health care interpretation workforce. **Baseline:** This is a new project; baseline at DY2 is zero. **Goal:** Train 60 staff members to serve as Spanish Bilingual Assistants **Data Source:** HR workforce training	**Milestone 9** [I-13]: Improve language access **Metric** [I-13.1]: The number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year. **Baseline:** This is a new project; baseline at DY2 is zero **Goal:** Perform a monthly average of 3010 qualified language interpreter encounters. **Data Source:** Program data and reports **Milestone 9 Estimated Incentive Payment: $ 1,284,522** **Milestone 10** [P-5]:Train/certify additional health care interpreters **Metric** [P-5.1]: Expand capacity of qualified health care interpretation workforce. **Baseline:** This is a new project; baseline at DY2 is zero. **Goal:** Train 60 staff members to serve as Spanish Bilingual Assistants **Data Source:** HR workforce training data, Program materials

UNIQUE IDENTIFIER: 137265806.1.4 – PASS 3	RHP PP REFERENCE NUMBER: 1.4.1	PROJECT COMPONENTS: 1.4.1 (A-D)	PROJECT TITLE: EXPAND ACCESS TO WRITTEN AND ORAL INTERPRETATION SERVICES: LANGUAGE SERVICES RESOURCE CENTER	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.7 – Pass 3*	*IT-11.6*	*Other Outcome Improvement Target*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
			data, Program materials **Milestone 7 Estimated Incentive Payment: $1,553,874**	**Milestone 10 Estimated Incentive Payment: $1,284,521**
Year 2 Estimated Milestone Bundle Amount: $2,881,622	**Year 3 Estimated Milestone Bundle Amount: $3,103,521**		**Year 4 Estimated Milestone Bundle Amount: $3,107,748**	**Year 5 Estimated Milestone Bundle Amount: $2,569,043**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):$11,661,934				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Culturally Competent Care
PROJECT ID: 137265806.1.5 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. The Travis County Health Care District owns UMCB and it is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project will provide culturally competent care training, awareness and education to healthcare providers and staff to increase the likelihood of safe and effective patient care, open communications and better health outcomes.

Need for the project: According to the 2010 US Census, ninety percent (90%) of the demographic growth in Central Texas over the last 10 years is due to growth within the Hispanic, African American and Asian American communities. A more diverse population will increase the need for culturally sensitive and linguistically accessible prevention and care (CN.17).

Target population: The target population is all patients of UMCB where the program will be piloted and patients at the three other acute-care hospitals where it will be implemented in DY5. The goal is to ensure each patient receives high-quality care regardless of racial, ethnic or socio-economic factors.

- **Category 1 or 2 expected patient benefits:** Over 3,500 health care providers at all levels, including nurses and doctor, will be trained to deliver cultural competent care by the end of DY5 as part of training conducted during the hospital's employee orientation, required annual competencies and/or continuing education programs. By the end of DY3, 5,250 patients (25% of UMCB's average annual patient census) will receive care from trained healthcare providers; we will accomplish this by training 25% of UMCB's healthcare providers in DY3.
- By the end of DY4, 10,500 patients (50% of UMCB's average annual patient census) will receive care from trained healthcare providers; we will accomplish this by training 50% of UMCB's healthcare providers in DY4.
- By the end of DY5, 27,900 patients (75% of UMCB's and 50% of the other three acute care hospitals' average annual patient census) will receive care from trained healthcare providers; we will accomplish this by training 75% of UMCB's healthcare providers and 25% of the healthcare providers at the other three hospitals in DY5.
- Cumulatively (DY3-DY5), this project will reach 43,650 patients of which 25% are expected to be Medicaid recipients and 54% expected to be indigent/uninsured individuals.

Category 3 Outcomes: Cultural Competency Care training has been demonstrated to improve patient satisfaction scores, quality of care, and better outcomes for patients who experience such care. [IT-6.1] Increase patient satisfaction scores of UMCB's HCAHPS survey specific to measurements in the modules *Communications with Doctors* and *Communications with Nurses* over baseline to be determined in DY3, by 3% in DY 4 and 5% in DY5.

Title of Project: **Clinical Cultural Competence: Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels: Culturally Competent Care Training**

Category / Project Area / Project Option: **1.4.4**

RHP Project Identification Number: **137265806.1.5 Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: 137265806

Project Description:

This project will provide culturally competent care training and education to healthcare providers and staff at UMCB and three other Seton hospitals in Travis County.

UMCB will develop a cultural competency training curriculum that recognizes diversity and encourages inclusion to increase provider awareness of racial and ethnic disparities in health care and the importance of socio-cultural factors on health beliefs and behaviors to improve patient outcome. The curriculum will cover health related attitudes and beliefs of men, women, veterans, children, geriatrics, individuals with disabilities, African American, Hispanic, Asian American, Lesbian, Gay, Bisexual and Transgender individuals that may affect health outcomes and the considerations for the delivery of healthcare. In *A Systematic Review of Health Care Provider Educational Interventions*, the authors reviewed 34 studies evaluating interventions to improve the cultural competence of health care professionals. They concluded "cultural competence training shows promise as a strategy for improving healthcare professional's knowledge, attitudes, and skills and patient's ratings of care" and recommended interventions focused on the avoidance of bias, general concepts of culture and patient-centeredness should be prioritized for further study.[12]

Project Components

This project will begin with an analysis to determine gaps in culturally competent care. A skill-based training curriculum, to be called "Diversity Skills Curriculum," will address those gaps.

The cross-cultural training program developed will be a required, integrated component of the training and professional development of healthcare providers at all levels and will be designed to:

- increase awareness of racial and ethnic disparities in health and the importance of social-cultural factors on health beliefs and behaviors;
- address the impact of race, ethnicity, culture, and class on clinical decision-making; and
- develop human resources skills for cross-cultural assessment, communication and negotiation.

[12] (Mary Catherine Beach, MD, MPH et al. Cultural Competence: A Systematic Review of Health Care Provider Educational Interventions. Medical Care, Volume 43, Number 4, April 2005, Page 367.)

The curriculum will use a person/patient-centered, coordinated learning model that increases awareness, promotes communication, builds skills and changes behavior. A pilot curriculum will be provided to all levels of healthcare professionals at UMCB via industry accepted facilitation processes. The pilot will be rolled out to three (3) other Seton hospitals in Travis County[13] in DY5. On-going training and workshops will be provided to update curriculum and refresh skills.

Project Goals:
This project will provide a diverse population of patients with access to health care delivered by culturally competent professions who understand and respond effectively to their cultural needs. The performing provider will institutionalize cultural knowledge within the hospital system to manage and adapt to the diverse and cultural context of individuals and the communities they serve.

This project meets the following regional goals:
Culturally competency training will increase the likelihood of safe and effective care, open communication, adherence to treatment protocols and positive health outcomes for the diverse population of this region.

Goal #3 - Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
Goal #7 - Improve the patient experience of care by increasing the quality of care and patient safety.

Challenges:
Leaders may be reluctant to invest in training due to concerns that time away from patients or mission critical projects may be viewed as non-productive time. To address this challenge, training will be integrated into existing learning programs, as well as meetings, roundings, managers meetings, retreats and other venues. Utilizing e-learning and webinar technology for selected modules wherever a self-paced training opportunity is appropriate, will be explored. The Performing Provider will also advocate for culturally competency training to become part of the annual staff training requirements, as doing so will encourage staff to recognized themselves as stakeholders and be accountable to the mission and objectives of curriculum.

Another challenge may be identifying subject matter experts to help design the curriculum. The Performing Provider will collaborate with organizations such as The Conference Board, Institute for Diversity in Healthcare Management, and American College of Healthcare Executives to identify and obtain such expertise.

5-Year Expected Outcome for Provider and Patients:
Approximately 3,500 clinical healthcare providers at all levels including nurses and doctors will be trained to deliver culturally competent care by the end of DY5. Culturally competent care is expected to reduce healthcare disparities, improve patient experience and contribute to the overall quality of health care provided to the community. By training 75% of the healthcare providers at UMCB, 75% of its patients will receive care from professionals who understand and respond to their cultural needs. Likewise, by training 50% of the staff at the other three hospitals, 50% of their patients will benefit. By the end of the demonstration project, 43,650 will benefit from this project.

[13] Seton Northwest Hospital (SNW) an acute care hospital with 124 beds; Seton Southwest Hospital (SSW) an acute care hospital with 33 beds); and Seton Medical Center Austin (SMCA) an acute care hospital with 474 beds.

Starting Point/Baseline:
Currently, there is no cultural competency training offered; therefore baseline is zero.
Rationale:
Austin is a global city. The racial and ethnic composition of Travis County residents is: 51% White, 34% Hispanic, 9% African American and 8% Other, which includes 5.8% Asian.[14] According to the 2010 US Census, ninety percent (90%) of the demographic growth in Central Texas over the last 10 years is due to growth within the Hispanic, African American and Asian American communities. Region 7 is projected to become increasingly diverse through 2016, with the greatest increases attributed to Hispanics (increasing from 34% of the region in 2010 to approximately 41% in 2016). Hispanics typically have higher rates of diabetes, obesity, and physical inactivity compared with Whites.[15] A more diverse population will increase the need for culturally sensitive and linguistically accessible prevention and care. Additionally, our workforce is evolving to reflect the diversity of our patients. As the region becomes more ethnically and racially diverse, health care systems and providers need to respond to patients' varied perspectives, values, beliefs, and behaviors about health and well-being. Failure to understand and manage socio-cultural differences can have significant health consequences for minority groups in particular.

Various systemic health disparity issues have been identified in the literature and by health care experts including the Institute of Medicine report *Unequal Treatment*, the *Healthy People 2020* report, and the Agency for Healthcare Research and Quality's *National Healthcare Disparities Report*. While this disparity was more obvious in poorly constructed and complicated systems which are not responsive to the needs of diverse patient populations, systems lacking culturally and linguistically appropriate health education materials lead to patient dissatisfaction, poor comprehension and adherence, and lower quality care. According to these various studies, care experts in government, managed care, academia, and community health care make a clear connection between cultural competence, quality improvement and the elimination of racial/ethnic disparities.

Available data shows disparities across many health conditions have the potential to be exacerbated by an increasingly culturally diverse population. The National Quality Forum (NQF-September 2012) states that "one essential step to improving the overall quality of healthcare performance is to eliminate disparities in care experienced by socially disadvantaged population groups. The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated racial and ethnic minorities often receive lower-quality care than their white counterparts, even after controlling for factors such as insurance, socioeconomic status, co-morbidities, and stage of presentation. Among other factors found to contribute to healthcare disparities are inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate linguistic access. To reduce healthcare disparities, healthcare systems likely will need to improve in all of these areas."

Project Components:

Unique community need identification numbers the project addresses:

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[14] U. S. Census Bureau, (2012). State & County Quick Facts: Bastrop, Caldwell, Fayette, Hays, Lee, and Travis Counties. Retrieved June 2012 from http://quickfacts.census.gov
[15] *RHP #7 Community Needs Assessment, Full Report, page 14, July 2012.*

CN.17 - Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The performing provider currently has no cultural competency training for health care providers and staff regarding health related issues and beliefs.

Related Category 3 Outcome Measures:
OD-6 Patient Satisfaction
IT- 6.1 Percent improvement over baseline of patient satisfaction scores, focusing only on the measures in the module " how well does my physician communicate."

Reasons/rationale for selecting the outcome measure:
The provider has selected the Related Category 3 Outcome Measure from the Outcome Domain: *Patient Satisfaction*, Percent Improvement Over Baseline of Patient Satisfaction Scores (IT-6.1). Provider will increase patient satisfaction scores of UMCB's Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey specific to measurements in the modules "communications with Doctors" and "communication with Nurses" by 3% above base in DY4 and by 5% in DY5 (baseline to be determined in DY2). HCAHPS was selected because evidence exists that shows hospitals with greater cultural competency have better HCAHPS scores for doctor communications.[16]

Empirical support exists for the potential usefulness of a patient-centered culturally sensitive health care model for explaining the linkage between the provision of patient-centered, culturally sensitive health care, and the health behaviors and outcomes of patients who experience such care. Greater hospital cultural competency may improve overall patient experiences, but may particularly benefit minorities in their interactions with nurses and hospital staff. Such effort may not only serve longstanding goals of reducing racial/ethnic disparities in inpatient experience, but may also contribute to general quality improvement.[17]

Further, the Institute of Medicine report, *Unequal Treatment*, suggests a link between improved communication and improved patient health status through improved patient satisfaction and adherence.[18] (Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care.* Washington, DC: The National Academies Press; 2002).

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[16] *Patient-centered culturally sensitive health care: Model testing and refinement;* Tucker, Carolyn M.; Marsiske, Michael; Rice, Kenneth G.; Nielson, Jessica Jones; Herman, Keith. Health Psychology, Vol 30(3), May 2011, 342-350. doi: 10.1037/a0022967. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3092156/

[17] *Can hospital cultural competency reduce disparities in patient experiences with care?* Weech-Maldonado R, Elliott M, Pradhan R, Schiller C, Hall A, Hays RD. Department of Health Services Administration, University of Alabama at Birmingham, AL 35294, USA. Med Care. 2012 Nov;50 Suppl:S48-55. doi: 10.1097/MLR.0b013e3182610ad1 www.ncbi.nlm.nih.gov/pubmed/23064277

[18] (Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care.* Washington, DC: The National Academies Press; 2002

Relationship to other RHP Projects:
This project is directly related to UMCB's Language Services Center project (137265806.1.4) through their mutual goals. This project also supports all other UMCB projects whose healthcare providers and staff members receive the training described herein.

List of Related Category 1 & 2 Projects
137265806.1.4 - Language Services Resource Center
137265806.1.3 – Psychiatric Telemedicine
137265806.1.5 – Expand Psychiatric Residencies
137265806.1.3 – Psychiatric Telemedicine for Emergency Services
137256806.2.1 – OB Navigation
137265806.2.2– Substance Abuse Navigation
137265806.2.3 – Behavioral Health Navigation
137265806.2.4 – Women's Oncology Screenings
137265806.2.5 – Care Transitions Intervention
137265806.2.6 – Chronic Care Management – Adults
137265806.2.7 – Palliative Care
137265806.2.8 – Women's Oncology Navigation
137265806.2.9 – Diabetes Chronic Care Management

List of Related Category 4 Projects
RD-1 – Potentially Preventable Admissions
RD-2.7 All-Cause: 30-Day Readmission
RD-4.1. Patient Satisfaction
RD-4.2. Medication Management

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
No other regional performing providers are establishing projects that provide cultural competency care training. RHP 15 has proposed two similar projects and a provider will reach out to those providers to share learnings and discuss challenges, ideas and solutions.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives.

Plan for Learning Collaborative:
The performing provider for culturally competent care training will fully participate in a RHP-wide learning collaborative for projects which directly address improving healthcare services to all patients and all projects providing clinical services to predominately diverse populations. Regular sharing between providers with similar projects and/ or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically.

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time,

and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE IDENTIFIER: 137265806.1.5 – PASS 3	RHP PP REFERENCE NUMBER: 1.4.4	PROJECT COMPONENTS: NONE	PROJECT TITLE: CLINICAL CULTURAL COMPETENCE: DEVELOP CROSS-CULTURAL TRAINING PROGRAM THAT IS A REQUIRED, INTEGRATED COMPONENT OF THE TRAINING AND PROFESSIONAL DEVELOPMENT OF HEALTH CARE PROVIDERS AT ALL LEVELS: CULTURALLY COMPETENT CARE TRAINING	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.8 – Pass 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]: Conduct an analysis to determine gaps in culturally competent care. Metric 1 [P-1.1]: Gap Analysis Goal: Produce a gap analysis report and estimate mix of patient demographics and diversity. Data Source: Program materials and finalized report. **Milestone 1 Estimated Incentive Payment: $1,685,519**	**Milestone 2** [P-2] Develop a program to enhance organizational, systemic, or clinical culture competence as described in the project options. Metric 3 [P-2.1]: Develop and implement program to improve cultural competence. Goal: Develop cultural competency training curriculum and provide training 800 staff Data Source: Program materials finalized curriculum and training records **Milestone 2 Estimated Incentive Payment: $ 907,675** **Milestone 3** [I-18]: Implement intervention to increase access to culturally competent care. Metric 5 [I-18.1]: Increase percentage of target populations reached by staff who have completed culturally competent care training. Goal: . 5,250 patients of target population reached by training 25% of staff at UMCB. Data Source: Documentation of target population reached, as designated in the		**Milestone 4** [I-18]: Implement intervention to increase access to culturally competent care. Metric 5 [I-18.1]: Increase percentage of target populations reached by staff who have completed culturally competent care training. Baseline: This is a new program; baseline at DY2 is zero. Goal: 10,500 of target population reached by training 50% of staff at UMCB. Data Source: Documentation of target population reached, as designated in the project plan. **Milestone 4 Estimated Incentive Payment: $1,817,786**	**Milestone 5 4** [I-18]: Implement Intervention to increase access to culturally competent care. Metric 7 [I-18.1]: Increase percentage of target populations reached by staff who have completed culturally competent care training. Baseline: This is a new program; baseline at DY2 is zero. Goal: 27,900 of target participation reached by training 75% of staff at UMCB and 50% of staff at SNW, SSW, and SMCA. Data Source: Documentation of target population reached, as designated in the project plan. **Milestone 5 Estimated Incentive Payment: $1,502,686**

UNIQUE IDENTIFIER: 137265806.1.5 – PASS 3	RHP PP REFERENCE NUMBER: 1.4.4	PROJECT COMPONENTS: NONE	PROJECT TITLE: CLINICAL CULTURAL COMPETENCE: DEVELOP CROSS-CULTURAL TRAINING PROGRAM THAT IS A REQUIRED, INTEGRATED COMPONENT OF THE TRAINING AND PROFESSIONAL DEVELOPMENT OF HEALTH CARE PROVIDERS AT ALL LEVELS: CULTURALLY COMPETENT CARE TRAINING	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.8 – Pass 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)
	project plan. **Milestone 3 Estimated Incentive Payment: $ 907,656**			
Year 2 Estimated Milestone Bundle Amount: $1,685,519	**Year 3 Estimated Milestone Bundle Amount: $1,815,313**		**Year 4 Estimated Milestone Bundle Amount: $1,817,786**	**Year 5 Estimated Milestone Bundle Amount: $1,502,686**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $6,821,304				

Austin Travis County Integral Care (ATCIC)
Category 2 DSRIP Projects

Austin Travis County Integral Care (ATCIC)
Integrate Primary and Behavioral Health Care Services
Project Identifier: 133542405.2.1 Pass 1

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has served as the local mental health authority for Travis County. ATCIC is Joint Commission accredited and the only dedicated outpatient specialty behavioral health provider in Austin that serves adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

Intervention(s): The goal of this project is to increase access and capacity to specialty behavioral health services by establishing a new outpatient clinic in south-southeast Austin. Additionally, the clinic will provide access to primary care services for adults with co-morbid chronic medical conditions - providing the right care in the right setting.

Need for the project: The regional (RHP-7) CNA revealed that almost 59 percent of Travis County patients with a mental health diagnosis also experienced a co-occurring medical condition. An additional 20 percent had a substance use disorder, including 13 percent who had tri-morbid conditions (mental health, substance use disorder and medical condition). The experience of adults with SMI who are accessing and establishing a primary care medical home in traditional clinic systems may present a barrier to care. Navigating these services is daunting for the patients and primary care providers due to complex clinical presentations, the neuroleptic medications regimen and functional/behavioral impairments. To ensure that these individuals receive the appropriate care, this integrated healthcare delivery strategy has been selected.

Target population: ATCIC contracts with the Texas Department of State Health Services to provide specialty behavioral health services for adults with SMI and children/youth with SED who are below 200 percent of the Federal Poverty Level. Currently, approximately 38 percent of individuals served by ATCIC have Medicaid and/or Medicare. All other individuals served are funded by state general revenue funds received from the Department of State Health Services.

Category 1 or 2 expected patient benefits: Process milestone/metric P-5 and improvement milestone/metric I-8 were selected as they are consistent with the RHP-7 goals of: 1) Expanding access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery, and 2) Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. Since this project is establishing a new clinic site baselines will have to be established for these milestones and metrics. It is anticipated that by DY-3 approximately 1800-2000 unduplicated adult and child patients combined will receive behavioral health services at this new clinic location.

Category 3 outcomes: Two Category 3 standalone improvement targets will be implemented for this project: 1) IT-1.18 - Follow-up after hospitalization for mental illness; and 2) IT-6.1 - Percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care,

appointments, and information. Since this project is establishing a new clinic site baselines will have to be established for these milestones and metrics.

Title of Project: **Integrate Primary and Behavioral Health Care Services**

Category / Project Area / Project Option: **2.15.1**

RHP Project Identification Number: **133542405.2.1 Pass 1**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description - This project addresses the challenge to increase access and the capacity of specialty behavioral health services in Austin and Travis County by establishing a new behavioral health outpatient clinic for children and adults. A fundamental component of this clinic is the integration of primary care services for adults with serious mental illness (SMI), to be done in collaboration with local federally qualified health clinic, CommUnityCare. Throughout the past 10 years, ATCIC has gained considerable experience in providing integrated behavioral health services in primary care clinics with CommUnityCare. Integrated services are a best practice and effective service delivery model used to address the chronic healthcare needs of adults with SMI (http://www.integration.samhsa.gov, August 20, 2012). This new outpatient behavioral health clinic would be located in the Dove Springs neighborhood of Austin and be the first specialty behavioral health clinic in south-southeast Austin - facilitating access to the right care at the right time and setting.

Since 1966, Austin Travis County Integral Care (ATCIC) has served as the local mental health authority for Travis County. ATCIC is Joint Commission accredited and the only dedicated outpatient specialty behavioral health provider in Austin that serves adults with SMI and children with Serious Emotional Disturbance (SED). ATCIC contracts with the Texas Department of State Health Services to provide specialty behavioral health services to people 200 percent below the Federal Poverty Level (FPL). Currently, approximately 38% of individuals served through ATCIC services have Medicaid and/or Medicare. All other individuals served are funded via State general revenue funds received from the Department of State Health Services.

Treatment and support needs for adults with SMI become increasingly complex in presence of co-morbid medical conditions. A recent study funded through the Robert Wood Johnson Foundation found the national prevalence rates of behavioral health and co-morbid medical conditions to be as high as 68 percent (Mental Health Disorders and Medical Comorbidity, The Synthesis Project No.21, Robert Wood Johnson Foundation, February 2011). The regional (RHP-7) Community Needs Assessment (CNA) revealed almost 59 percent of Travis County patients with a mental health diagnosis also experienced a co-occurring medical condition. To address the co-morbid conditions of adults with SMI at this new clinic, ATCIC will provide primary care services in three dedicated exam rooms to be used by the primary care team. Additionally, ATCIC will also provide and coordinate health promotion and wellness services to enhance and improve overall health outcomes for consumers.

In FY 2012, ATCIC served 7,500 unduplicated adults with SMI and 2,600 unduplicated children with SED in a third dedicated pediatric behavioral health clinic location. Of this total of 10,100 consumers, approximately 1,700 adults and 570 children and their families reside in south-southeast Austin and must travel to a central or north Austin location to receive services from ATCIC. These capacity limitations delay access to an initial psychiatric evaluation and treatment for adults with SMI seeking services a range of 90-120 days and 30 days or more for children with SED. Such obstacles to access treatment can result in delayed care or individuals to treatment at medical hospital emergency departments and/or ATCIC's psychiatric emergency services, the most expensive points of service in our systems.

It is imperative to create additional capacity and access to specialty behavioral healthcare services for adults and children in Austin. The three existing ATCIC outpatient clinic sites are located in north and central Austin, leaving a significant gap for residents of south-southeast Austin who necessitate ready and convenient access to outpatient behavioral health services. This clinic will be located in the Dove Springs neighborhood where approximately 39,000 individuals reside. Eighteen percent of families are below the FPL and 53 percent speak a language other than English at home (Central Health, Board of Managers retreat presentation, April 30, 2011). Further, the Children's Optimal Health collaborative conducted an analysis utilizing a Geographical Information System and found a high concentration of adults with SMI and SMI with co-morbid medical conditions residing in southeast Austin (Children's Optimal Health, 2012). Increasing access to specialty community-based behavioral health services is facilitated by clinic locations close to the places that individuals and families live, work and attend school.

Project Goals - The goal of this project is to increase access and capacity to provide specialty behavioral health services by establishing a new outpatient clinic in south-southeast Austin to provide the right care in the right setting. Additionally, the clinic will provide access to primary care services for adults with co-morbid chronic medical conditions. It is anticipated that by DY-3 approximately 1800-2000 unduplicated adult and child patients combined will receive behavioral health services at this new clinic location. The goal during four years is to increase the number of new consumers (adults/children) predominantly residing in southeast Austin and accessing behavioral health services by five percent in DSRIP year (DY) 4 and 10 percent in DY 5. The new clinic will also create additional capacity and access for the three existing outpatient clinics as these consumers transition their care, facilitate timely appointments, improve continuity of care, assist with averting crises and ultimately decrease use of costly alternatives such as hospital emergency departments.

To establish this new clinic location, ATCIC will lease a facility with sufficient capacity to provide both adult and child psychiatric services and primary care services for adults. All remodeling/construction costs for this new facility will be included in the terms of lease. Leasing this facility is a necessary requirement for the project as ATCIC has no facilities or established presence in this area of Austin.

Challenges or Issues Faced by the Performing Provider –

1. South and southeast Austin has never had an outpatient behavioral health services clinic. A challenge in establishing this new service site will be to inform the local community, other service providers and established consumers of services of the availability of this new clinic.

2. Timely recruitment of psychiatric providers is a second challenge in establishing this new clinic. Availability of psychiatric providers interested in delivering specialty community-based outpatient services is a challenge for our community.
3. A third challenge for the new clinic will be recruiting bilingual employees who speak Spanish and understand the bi-cultural needs of the surrounding community.
4. The education and training of psychiatric and primary care medicine providers in integrated care is the fourth challenge for this new clinic. Traditional medical practices and training have approached the provision primary care medicine and psychiatric medicine as distinctly separate.

How the Project Addresses those Challenges –
1. A key factor for the success of this project includes providing community outreach to notify the community of the new clinic's location, populations to be served, clinical services provided and how to access those services. Community education forums, brochures and engagement of key community partners will be utilized to achieve this. 2. ATCIC will address the provider recruitment challenge by partnering with an external provider to establish telepsychiatry services at the new clinic. This will help with access and flexibility in providing timely psychiatric assessments/consultations, particularly when a person presents with urgent needs. 3. ATCIC will recruit local members of the professional, medical and nursing programs in Austin, San Antonio and throughout Texas. In addition, every effort will be made to recruit individuals from south-southeast Austin neighborhoods who culturally, ethnically and linguistically represent the community. 4. ATCIC's gained experience in working with FQHC partner, CommUnityCare, will facilitate the education, training and the coordination of care and services. Vital to this effort is ensuring access to ATCIC's health promotion and wellness initiatives to ensure adults with SMI utilize services such as tobacco cessation, exercise and dietary programs to improve health outcomes.

How the Project is Related to RHP Goals – The six counties that comprise RHP Region 7 in Texas have identified seven RHP goals, of which, the following five relate to this project:

Goal 2 - Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
Goal 3 - Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
Goal 4 - Bolster individual and population health by improving chronic disease management.
Goal 5 - Support prevention education and healthy lifestyles to improve population health.
Goal 6 - Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery

Starting Point/Baseline

Baseline Data – As this will be a new outpatient specialty behavioral health services clinic a baseline for integrated health and behavioral health services must be established.

Time Period for Baseline – Baseline will be established in DY 3.

Rationale

Reason for Selection of Project Options and Components – The regional (RHP-7) CNA revealed that almost 59 percent of Travis County patients with a mental health diagnosis also

experienced a co-occurring medical condition. An additional 20 percent had a substance abuse disorder, including 13 percent who had tri-morbid conditions (mental health, substance use disorder and medical condition). The experience of adults with SMI who are accessing and establishing a primary care medical home in traditional clinic systems may present a barrier to care. Navigating these services is daunting for both the patient and/or primary care provider due to complex clinical presentations, the neuroleptic medications regimen and functional/behavioral impairments. To ensure that these individuals receive the right care this integrated healthcare delivery strategy has been selected. Components of this project include:

a) *Identify sites for integrated care projects, which would have the potential to benefit a significant a number of patients in the community.* ATCIC will establish a new clinic site will be located in south-southeast Austin, a part of our community that has no specialty behavioral health outpatient behavioral health services readily available.

b) *Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.* ATCIC's primary care partner, CommUnityCare, have a long history of providing integrated services. Formal provider agreements will not be required.

c) *Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.* Yes, protocols will be established to ensure that providers have mechanisms for sharing data, referrals and to ensure continuity of care.

d) *Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.* Yes, ACTIC will recruit behavioral health providers and staff for this new clinic location. CommUnityCare will recruit, employ and train the primary care team and provider.

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:

1) *Regular consultative meetings between physical health and behavioral health practitioners* Yes, all medical providers, nursing staff and medical assistants will participate in joint staffing meetings and be fully integrated into clinic functions, meetings and protocols.

2) *Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners* Yes, providers will share in "bullpen" type office that will facilitate interactions. Also, establishing the practice of "warm handoffs" will be an expectation from the outset.

3) *Shared treatment plans co-developed by both physical health and behavioral health practitioners.* Currently the EHRs used by CommUnityCare and ATCIC are separate. Discussion has been underway to develop a portal through which providers will access records to ensure continuity of care. Ultimately, the goal would be to develop a shared record.

f) *Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.* Yes, developing a health information exchange is project being actively explored by our community. ATCIC is very interested in being an active participant in this effort as it develops. Although, an integrated health record is not available the use of patient registries to monitor care and ensure continuity of services between disciplines will be employed.

g) *Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.* Yes, ATCIC and CommUnityCare have a long history and standing legal agreements between our two agencies.

h) *Arrange for utilities and building services for these settings.* Yes, a potential site has been identified and ATCIC has established building contractors to manage the physical setting**.**

i) *Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.* Yes, ATCIC and CommUnityCare have an established history of tracking and sharing individual patient outcomes, aggregate services data and contract performance measures to ensure the quality of services.

j) *Conduct quality improvement for project using methods such as rapid cycle improvement.*

Yes, CQI activities will focus on rapid cycle process improvements to ensure that clinical care, clinic processes and communication is optimized. Reports will be produced and consultations with all team members will be utilized to discuss outcomes, potential for improvement and successes.

Reason for Selection of Milestones & Metrics – Process milestone/metric P-5 and improvement milestone/metric I-8 were selected as they are consistent with the RHP-7 goals of: 1. Expanding access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery, and 2. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

Unique Community Need Identification Number – CN.2, CN.4, CN.6, CN.10, CN.15, CN.16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative – Although ATCIC has extensive experience in providing outpatient specialty behavioral health services this project will establish a new clinic site and embed primary care services into its service array.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) – None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected – Two Category 3 standalone improvement targets will be implemented for this project: 1) OD-1: Primary Care and Chronic Disease Management, IT-1.18 - Follow-up after hospitalization for mental illness; and 2) OD-6: Patient Satisfaction, IT-6.1 - Percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information.

Reasons/Rationale for Selecting the Outcome Measure(s) – The CNA reveals that Travis County experienced a 33 percent increase in inpatient psychiatric hospitalizations from 2008 to 2010. In Travis County, suicides are the eighth leading cause of death and the fourth leading preventable cause of death. Research indicates that the weeks after discharge represents a critical period for suicide risk. (Hunt et al. Psychological Medicine (2009). 39, 443-449) Establishing a new outpatient clinic location will assist people to receive timely psychiatric follow-up post psychiatric hospitalization. Timely psychiatric follow-up supports a person's psychiatric stabilization and improved functioning. Further, problems that the person encountered prior to and leading to hospitalization may be addressed to assist in averting deterioration in functioning and re-hospitalization. For example: if a person's lack of financial resources resulted in an inability to purchase psychiatric medications with a consequence of worsening functioning led to eventual hospitalization, then clinic staff providing follow-up would promptly address this need thereby supporting the person's continued recovery post-hospitalization.

For people with co-morbid conditions, measuring the availability and timeliness of primary care and appointments that meet clients' needs is essential. Measurement of this outcome underscores one of RHP-7 goals of improving the patient experience of care by investing in timely, patient-centered, integrated, comprehensive care that is coordinated across systems.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

ATCIC is also proposing to expand behavioral health services through its Mobile Crisis Outreach Team expansion.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

133542405.2.2 - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Mobile Crisis Outreach Team Expansion

List of Related Category 4 Projects N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

133340307.2.1: Hays County Mental Health Center Integrated Care
133542405.2.6: Integrate Whole Health Peer Support:
133542405.1.2: Expand Specialty Behavioral Healthcare Prescriber Capacity
126844305.2.4: Primary Care / Behavioral Health Care Integration Clinic –
307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
307459301.2.3: Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients
307459301.1.8: Telepsychiatry in Federally Qualified Primary Health Clinics
307459301.1.3: Mobile Primary Care

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects – Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project –

The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the

performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing specialty behavioral health services for children/youth and adults in an area of our community south – southeast Austin and the Dove Springs neighborhood. Additionally, integrated primary care/behavioral health services will be provided to adults with SMI at this clinic site thereby providing the right service, at the right time in the right location.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.2.1	***2.15***	***2.15.1 A-J***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTHCARE SERVICES***
Austin Travis County Integral Care			*133542405*
Related Category 3 Outcome Measure(s):	*133542405.3.1* *133542405.3.2*	*IT-1.18, IT-6.1*	*IT-1.18-Follow-up After Hospitalization for Mental Illness & IT-6.1 Percent Improvement over baseline for 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: Develop integrated sites reflected in the number of locations and providers participating in the integration project	**Milestone 2** P-X: Establish baseline rates	**Milestone 3** I-8: Integrated Services	**Milestone 4** I-8: Integrated Services
Metric 1 P-5.2: Number of primary care providers newly located in behavioral health settings	Metric 1P-X.1: Establish baseline for the number of individuals receiving both physical and behavioral healthcare services at established location	Metric 1 I-8.1: Percent of individuals receiving both physical and behavioral healthcare at the established location	Metric 1 I-8.1: Percent of individuals receiving both physical and behavioral healthcare at the established location
Baseline/Goal: 1 primary care provider	Goal: Establish Baseline	Goal: Increase volume of new patients receiving integrated care services by 5% over baseline	Goal: Increase volume of new patients receiving integrated care services by 10% over baseline
Data Source: Project Data	Data Source: EHR & project data	Data Source: EHR	Data Source: EHR
Milestone 1 Estimated Incentive Payment: $4,674,285	Milestone 2: Estimated Incentive Payment: $4,859,261	Milestone 3: Estimated Incentive Payment: $5,198,280	Milestone 4: Estimated Incentive Payment: $5,210,344
Year 2 Estimated Milestone Bundle Amount: $4,674,285	Year 3 Estimated Milestone Bundle Amount: $4,859,261	Year 4 Estimated Milestone Bundle Amount: $5,198,280	Year 5 Estimated Milestone Bundle Amount: $5,210,344
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,942,170			

Austin Travis County Integral Care
Mobile Crisis Outreach Team (MCOT) Expansion
Performing Provider: 133542405.2.2 Pass 1

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has provided services for children, families and adults with behavioral health disorders. In fiscal year (FY) 2011, more than 23,000 individuals and families received services from ATCIC.

Intervention(s): ATCIC proposes expanding its Mobile Crisis Outreach Team (MCOT) capacity at key community intercept points to provide specialty behavioral health crisis intervention services for Medicaid eligible and/or indigent individuals by adding MCOT employees 24/7 at: Travis County Jail central booking, the two highest psychiatric volume emergency departments and pairing MCOT staff 24/7 with two trained Mental Health Crisis Intervention Team officers.

Need for the project: This expansion will divert inpatient admissions, jail bookings and emergency department (ED) admissions, provide short-term community-based interventions to stabilize a person in a psychiatric crisis and link them to ongoing supports. Since 2008, the number of emotionally disturbed person reports received by the Austin Police Department has increased 170 percent. In 2012, individuals who experienced a psychiatric crisis at local ED's waited an average of 15.63 hours in January 2012 – a 39 percent increase of wait time from FY 2011. For FY2011, Travis County jail data shows that approximately five percent of individuals booked into the jail experience severe and persistent mental illness and approximately 15 percent were identified with a behavioral health disorder. By stationing MCOT teams with local ED personnel, police in the community and central booking at the county jail can take advantage of naturally occurring, critical opportunities to divert Medicaid eligible and/or indigent individuals from costly emergency, non-specialty systems and alternatively provide specialty treatment.

Target population: The expanded MCOT model will target Medicaid eligible and/or indigent individuals in a psychiatric crisis who come in contact with ED's, law enforcement and central booking receive appropriate, cost-effective care to address their specific needs. Currently, 38 percent of ATCIC's consumers have Medicaid and 62 percent are indigent. Because this project targets a similar Medicaid eligible and indigent population, ATCIC anticipates this target population will mirror the population primarily served by ATCIC.

Category 1 or 2 expected patient benefits: This project seeks to decrease preventable criminal system admissions and readmissions by five percent compared to baseline in DSRIP Year (DY) 4 and 10 percent compared to baseline in DY5. Improvement milestone/metric I-1 corresponds with the RHP 7 goals: 1) reduce health system costs by expanding access for patients and families to the most appropriate care in the most appropriate setting, and 2) improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. It is anticipated that by DY-3 approximately 2000 duplicated individuals will receive crisis intervention services from the proposed MCOT team.

Category 3 outcomes: One Category 3 standalone improvement target will be implemented for this project: IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. By expanding ATCIC mobile capacity to respond to patients at the key system intercept points where individuals engage in the emergency and police systems, an opportunity is created to link individuals in psychiatric crisis to alternative community-based services and decrease Potentially Preventable Readmissions

Title of Project: Provide and intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Mobile Crisis Outreach Team (MCOT) Expansion

Category / Project Area / Project Option: **2.13.1**

RHP Project Identification Number: **133542405.2.2 Pass 1**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description - Established in 1966, Austin Travis County Integral Care (ATCIC) serves as the local mental health authority for Travis County and receives local, state and federal funds. ATCIC proposes expanding its Mobile Crisis Outreach Team (MCOT) capacity at key community intercept points to provide specialty behavioral health crisis intervention services. Currently, 38 percent of ATCIC's consumers have Medicaid and 62 percent are indigent. Because this project targets a similar Medicaid eligible and indigent population, ATCIC anticipates this target population will mirror the population primarily served by ATCIC.

As a best practice model in the field of psychiatric crisis care, MCOT's are designed to provide site-based psychiatric crisis intervention services in the community, assess and stabilize an individual experiencing immediate behavioral health crisis (e.g., an individual in immediate risk of harm to self or others due to a mental health condition). MCOT's are also designed to provide short-term follow up services to further stabilize an individual experiencing a behavioral health crisis and link the individual to appropriate resources. This MCOT expansion includes adding employees 24/7 to the following critical community intercept points: Travis County Jail at central booking, the two highest psychiatric volume emergency departments (Seton's University Medical Center and St. David's South Austin) and law enforcement by pairing MCOT staff 24/7 with two trained Mental Health Crisis Intervention Team (CIT) officers.

This expansion will meet the goals to divert inpatient admissions, jail bookings and emergency department (ED) admissions, provide short-term community-based interventions to stabilize a person in a psychiatric crisis and link them to ongoing supports.

Recommended best practices from The American Psychological Association (APA) for psychiatric crisis services identify MCOT as a key component of a comprehensive community psychiatric crisis continuum (Allen, M., Forster, P., Zealberg, J., & Currier, G. (2002). *Report and recommendations regarding psychiatric emergency and crisis services: A review and model program descriptions*. APA Task Force on Psychiatric Emergency Services). Research literature also underscores that police and emergency mental health professionals collaboration is essential because individuals experiencing a behavioral health crisis frequently first come in contact with law enforcement who often act as gatekeepers, determining whether an individual is arrested or linked to mental health care (Lamb, H.R., Weinberger, L.E., & DeCuir, W.J., (2002). "The police and mental health." *Psychiatric Services, 52*(10), 1266-1271). Local statistics from law enforcement, ED's and central booking at the county jail bear out this reality. Since 2008, the number of EDP (emotionally disturbed person) reports received by the Austin Police Department (APD) increased 170 percent. In

2012, individuals experiencing a psychiatric crisis at local ED's waited an average of 15.63 hours in January 2012 – a 39 percent increase of wait time from fiscal year (FY) 2011 (Psychiatric Stakeholder Committee, 1/2012 report). For FY2011, Travis County jail data shows that approximately 5 percent of individuals booked into the Travis County jail experience severe and persistent mental illness and approximately 15 percent were identified with a behavioral health disorder (Travis County Sheriff's Department, FY2011). Moreover, in FY2011 the average length of jail stay for an individual identified with a behavioral health disorder was 54 days and 17 days for individuals in the general population (Travis County Sheriff's Department, FY2011). By stationing MCOT teams with local ED personnel, police in the community and central booking at the county jail, we can take advantage of naturally occurring, critical opportunities to divert Medicaid eligible and/or indigent individuals from costly emergency, non-specialty systems and alternatively provide specialty treatment.

MCOT services include site-based psychiatric screening and psychiatric crisis assessment, access to a prescriber as needed, diversion to appropriate community-based care and resources and short-term follow-up to ensure the individual's immediate crisis is stabilized and the individual is linked with ongoing care and resources. During FY2012, ATCIC's Crisis Hotline data shows that law enforcement and ED personnel initiated continuity of care contacts for 4,353 individuals (duplicated) experiencing a psychiatric crisis in the community. In that same time period, MCOT made an average number of 3.6 visits per consumer to stabilize the immediate crisis and link them to care. Based on these numbers, the proposed MCOT expansion will be well positioned to reach these individuals in the community at the site of the crisis, provide appropriate treatment and divert potentially preventable behavioral health and criminal justice admissions and readmissions.

Project Goals

The goal of this proposed project is to decrease behavioral health (includes substance use) 30-day readmission rates and decrease preventable criminal system admissions and readmissions by five percent compared to baseline in DSRIP Year (DY) 4 and 10 percent compared to baseline in DY5. It is anticipated that by DY-3 approximately 2000 duplicated individuals will receive crisis intervention services from the proposed MCOT team. By expanding mobile capacity to respond to patients at the time these individuals come in contact with key system intercept points, individuals in crisis will receive appropriate, cost-effective care at the right time and right place by specialty behavioral health providers.

Challenges or Issues Faced by the Performing Provider

This project targets individuals who may not have previously sought help from behavioral health providers. These "new" patients will further strain the capacity of an already strained local behavioral health system yet. To meet this increased demand, added capacity will be needed in four key areas:

1. Access to prescribers (CN.4)
2. Hotline staff to assess and triage referrals (CN.15)
3. Crisis residential capacity to meet the need for appropriate crisis disposition options (CN.16)
4. Primary providers of routine specialty care behavioral health treatment services (CN.5)

The second set of challenges corresponds with the implementation of effective processes for planning efforts to ensure ATCIC's effective communication with the four community organizations: central booking, law enforcement and the two independently operated EDs. Already, the stage has been set early through several formal, longstanding and multi-level community processes to address this challenge.

How the Project Addresses those Challenges

To meet the need for added behavioral health capacity, the following plans have been initiated.

1. Access to prescribers (CN.4): *MCOT will use telemedicine, currently proposed project in RHP 7*
2. Hotline staff to assess and triage referrals (CN.15): *included as part of this proposed project*
3. Crisis residential capacity to meet the need for appropriate crisis disposition options (CN.16): *currently proposed project in RHP 7*
4. Primary provider of routine, community based specialty behavioral health treatment services (CN.5): *currently proposed project in RHP 7 to link individuals with ongoing behavioral health treatment with integrated primary care*

Existing local planning efforts have already set the stage to address the second challenge. In 2007, Central Health, the county healthcare district and RHP anchor, convened a local Psychiatric Stakeholders Committee comprised of high-level representatives from law enforcement, local hospitals, ATCIC, Travis County and others who work with individuals who have behavioral health issues. This group was formed to identify and address the unmet needs for persons in crisis. As part of the Psychiatric Stakeholders Committee, a Crisis Intervention Committee (CIC) was formed to function as a work group to review mutually identified community measures, identify needs and gaps and propose solutions for the larger stakeholder group. These efforts have resulted in tangible improvements and investments in healthcare for Travis County citizens, including the allocation of $9 million for inpatient psychiatric care in FY 2012. At a more hands-on level, ED social workers have been meeting with ATCIC crisis employees on a quarterly to bi-quarterly basis for approximately five years to identify, inform and address issues as they arise. Similarly, ATCIC crisis employees and local CIT law enforcement officers meet on a quarterly basis. Beginning in February 2012, APD partnered with ATCIC as the community behavioral health authority to provide training about mental illness to CIT officers and new police department cadets. These joint trainings are the fruit of several years of collaboration and bridge building. These existing collaborative relationships will serve as the foundation for continued growth and development of ongoing formal and informal communication processes to ensure the success of this project.

How the Project is Related to RHP Goals

The six counties that comprise RHP Region 7 in Texas have identified seven RHP goals, five of which relate to this proposed project:

Goal 2 - Reduce health system costs by expanding opportunities in which patients and families can access the most appropriate care in the most appropriate setting
Goal 3 - Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems
Goal 4 - Bolster individual and population health by improving chronic disease management
Goal 6 - Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery
Goal 7 - Improve the patient experience of care by increasing the quality of care and patient safety.

Starting Point/Baseline

Baseline Data

During FY2012, ATCIC's Crisis Hotline data shows that law enforcement and ED personnel initiated continuity of care contacts for 4,353 individuals (duplicated) experiencing a psychiatric crisis in the community. During this same time period, ATCIC's MCOT made an average number of 3.6 visits per consumer to stabilize the immediate crisis and link clients to care. Based on this data, proposed capacity and the normal anticipated and unanticipated challenges that arise with any new program, it is believed the

proposed MCOT expansion will provide crisis intervention services to 2,000 duplicated individuals during DY3.

Rationale

Reason for Selection of Project Options and Components

With 26 percent population growth in Travis County from 2000-2006 and a projected seven percent growth rate through 2016, the demand on the community's psychiatric crisis safety net will increase *(RHP-7, CNA, Central Health, Travis County, Sept. 2012).* Increased targeted mobile capacity aims to:

(1) Reduce the burden and costs on local EDs and increase both consumer and public safety by providing specialized behavioral health services;
(2) Provide behavioral health treatment alternatives to incarceration; and
(3) Maximize law enforcement time, resources and community safety

By targeting central booking and CIT officers in the field, minority populations will have an opportunity to receive appropriate specialty behavioral health treatment and care (CN.17 and CN.4).

The expanded MCOT model will ensure individuals in a psychiatric crisis who come in contact with ED's, law enforcement and central booking receive appropriate, cost-effective care to address their specific needs. This project will be addressing all of the project components. The following project components will be completed: (a) assess size, characteristics and needs of target population: *size, characteristics and needs of the target population have been identified in this proposal and will continue to be assessed during DY2* (b) review literature and experiences similar to target populations to determine community-based interventions that are effective in averting negative outcomes: *literature and experiences similar to target populations will continue to be reviewed and community based interventions that are effective in averting negative outcomes that have been identified in this proposal will be further refined during DY2* (c) develop project evaluation plan using qualitative and quantitative metrics to determine outcomes: *a project evaluation plan will be developed using qualitative and quantitative metrics to determine outcomes during DY2-DY3* (d) design models that include an appropriate range of community services and residential supports: *models will continue to be developed and designed that includes an appropriate range of community services and residential supports in DY2-DY3* and (e) assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population: *the impact of interventions will be assessed based on standardized quantitative measures and qualitative analysis relevant to the target population from DY3 through DY5*.

Reason for Selection of Milestones & Metrics

Process milestone/metric P-7 was selected to promote ongoing learning and exchanges between providers and collectively decide how to "raise the floor" of performance across all providers. Process milestone/metric P-3 was selected based on anticipated readiness to enroll and serve individuals in psychiatric crisis with ED's, law enforcement and central booking. Improvement milestone/metric I-1 was selected to correspond with the RHP 7 goal to: (1) reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting, and (2) improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

Unique Community Need Identification Number

CN.1, CN.4, CN.6, CN.7, CN.8, CN.15, CN.16, CN.17

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative –Expanding MCOT at key intercept points adds to ATCIC's existing community-based behavioral health crisis continuum which currently includes: a 24 hour Psychiatric Emergency Services, 24 hour American Association of Suicidology accredited Hotline and national Lifeline services, 24 hour MCOT, crisis residential and crisis respite services. Approximately 23,520 duplicated individuals received ATCIC's crisis services in FY2011.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) – None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected – OD-3: Potentially Preventable Readmissions – 30 day Readmissions Rates. One Category 3 standalone improvement target will be implemented for this project: 1) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. Process milestones P-1, Project Planning (DY-2) and P-2, Establish Baseline Rates (DY-3) are the corresponding measures selected for Category 3 outcomes.

Reasons/Rationale for Selecting the Outcome Measure(s)

The Community Needs Assessment for RHP-7 reveals that Travis County experienced a 33 percent increase in inpatient hospitalizations from 2008 to 2010. For FY2012 to date, readmission rates to inpatient psychiatric hospitals within 30 days is 14.4 percent, a two percent increase from FY2011 (Central Health, CIC, 9/12 Report). By expanding ATCIC mobile capacity to respond to patients at the key system intercept points where individuals engage in the emergency and police systems, an opportunity is created to link individuals in psychiatric crisis to alternative community-based services and decrease Potentially Preventable Readmissions, or PPRs.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

133542405.2.3: Crisis Residential Program,
133542405.2.4: Community Behavior Support (CBS) Team
133340307.1.1 Hays County Mental Health Center Mobile Clinic
201320302.2.1 Provide ACT Model for Participants of HF PSH
137265806.1.1: Psychiatric Emergency Department
137265806.1.3: Psychiatric Telemedicine for Emergency Services
137265806.2.4: Behavioral Health Assessment and Resource Navigation

List of Related Category 4 Projects *N/A*

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Other Performing Provider's projects with similar target populations and/or diagnoses include the City of Austin's proposal to Provide ACT Model for Participants of HF PSH (201320302.2.1), Dell Children's Medical Center's proposal for School Campus Counseling (186599001.1.1), and Hill Country MHDD's proposals for the Hays County Mental Health/Intellectual & Developmental Disability Crisis Center (133340307.2.2) and Co-occurring Psychiatric and Substance Use Disorder (133340307.2.3).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives - smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project - The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, community benefit and cost reduction to the healthcare system. In considering the incentive portion of the valuation, three principles and their subsequent impacts were taken into account. These principles include: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. By adding MCOT capacity at key community intercept points (Travis County Jail central booking, the two highest psychiatric volume emergency departments and paired with two trained Mental Health Crisis Intervention Team law enforcement officers), an opportunity is created to divert inpatient psychiatric admissions, jail bookings and emergency department (ED) admissions, provide short-term community-based interventions to stabilize a person in a psychiatric crisis and link these individuals to ongoing supports.

Calculating the value of interventions for this project for a specialty behavioral health population was done using an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often frequent users of the healthcare system. They also frequently present with a

number of functional impairments that lead to involvement in the criminal justice system. Incremental improvements in their behavioral and physical health status have a significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare and criminal justice systems.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.2.2	***2.13***	***2.13.1 A-E***	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, emergency departments, urgent care etc.)
Austin Travis County Integral Care			*133542405*
Related Category 3 Outcome Measure(s):	*133542405.3.3*	*IT-3.8*	*IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-7: Participate in face-to-face learning (ie, 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 P-7.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Complete at least two meetings or seminars with other providers and the RHP a. Data Source: Documentation of semiannual meetings including meeting agendas, slices from presentations, and/or meeting notes b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The	**Milestone 2** P-7: Participate in face-to-face learning (ie, 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 P-7.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Complete at least two meetings or seminars with other providers and the RHP a. Data Source: Documentation of semiannual meetings including meeting agendas, slices from presentations, and/or meeting notes b. Rationale/Evidence: Investment in learning and sharing of ideas is central to	**Milestone 4** I-1: Criminal Justice Admissions/Readmissions Metric I-1.1: Decrease in preventable admissions and readmissions into Criminal Justice System; a. Numerator: The percentage of individuals receiving specialized interventions that had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period b. Denominator: The number of individuals receiving specialized interventions. *This would be measured at specified time intervals throughout the project to determine if there was a decrease.* Goal: Decrease of 5% below baseline Data Source: local EHR and local jail records Rationale/Evidence: See project Goal Milestone 4 Estimated Incentive Payment: $2,443,475	**Milestone 6** I-1: Criminal Justice Admissions/Readmissions Metric I-1.1: Decrease in preventable admissions and readmissions into Criminal Justice System; a. Numerator: The percentage of individuals receiving specialized interventions that had a potentially preventable admission/ readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period b. Denominator: The number of individuals receiving specialized interventions. *This would be measured at specified time intervals throughout the project to determine if there was a decrease.* Goal: Decrease of 10% below baseline Data Source: local EHR and local jail records Rationale/Evidence: See project Goal Milestone 6 Estimated Incentive Payment: $2,443,475 **Milestone 7**

133542405.2.2	***2.13***	***2.13.1 A-E***	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, emergency departments, urgent care etc.)
Austin Travis County Integral Care			*133542405*
Related Category 3 Outcome Measure(s):	*133542405.3.3*	*IT-3.8*	*IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
highest quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 1 Estimated Incentive Payment:$5,165,610	improvement. The highest quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 2 Estimated Incentive Payment: $2,443,475 **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: P-3.1. Metric: Number of targeted individuals enrolled/served in the project. Baseline/Goal: 2,000 (duplicated) individuals a. Project documentation	**Milestone 5** P-7: Participate in face-to-face learning (ie, 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: P-7.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Complete at least two meetings or seminars with other providers and the RHP c. Data Source: Documentation of semiannual meetings including meeting agendas, slices from presentations and/or meeting notes d. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest	P-7: Participate in face-to-face learning (ie, 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: P-7.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Complete at least two meetings or seminars with other providers and the RHP a. Data Source: Documentation of semiannual meetings including meeting agendas, slices from presentations and/or meeting notes b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the

133542405.2.2	***2.13***	***2.13.1 A-E***	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, emergency departments, urgent care etc.)
Austin Travis County Integral Care			*133542405*
Related Category 3 Outcome Measure(s):	*133542405.3.3*	*IT-3.8*	*IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 3 Estimated Incentive Payment: $2,443,475	quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 5 Estimated Incentive Payment: $2,443,475	floor" for performance across all providers. Milestone 7 Estimated Incentive Payment: $2,443,475
Year 2 Estimated Milestone Bundle Amount: $5,165,610	Year 3 Estimated Milestone Bundle Amount: $4,886,950	Year 4 Estimated Milestone Bundle Amount: $4,886,950	Year 5 Estimated Milestone Bundle Amount: $4,886,950

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,826,460

Austin Travis County Integral Care
Hospital and Jail Alternative Project: Crisis Residential Program, Development of behavioral health crisis stabilization services as alternatives to hospitalization
Project Identifier: 133542405.2.3 Pass 2

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has provided services for children, families and adults with behavioral health disorders. In fiscal year (FY) 2011, more than 22,000 individuals and families received services from ATCIC.

Intervention(s): This program will specialize in providing psychiatric crisis care for individuals diagnosed with co-occurring substance use and mental health disorders. Crisis residential services are designed to provide short-term, community-based intensive psychiatric treatment for persons experiencing a psychiatric crisis that may pose some risk of harm to self or others and/or may have severe functional impairment.

Need for the project: Currently there are no local *specialized* crisis residential treatment alternatives immediately accessible for Medicaid eligible and/or indigent individuals with co-occurring substance use and mental health disorders. The prevalence of behavioral health conditions among adults with a substance use diagnosis is approximately 43 percent. In FY2010, the average inpatient cost per individual with four or greater re-readmissions within 30 days was $28,288 and the estimated cost of inpatient hospitalization was $368,000, while the cost for a visit to the ED is an average of $1,265. In FY2011, Travis County jail data showed that approximately 5 percent of individuals booked experienced severe and persistent mental illness and approximately 15 percent were identified with a behavioral health disorder. During FY2011 the average length of incarceration for individuals with a behavioral health disorder was 54 days, versus 17 days for individuals who did not. Treatment for a person with mental illness who is incarcerated averages $137 per day. The majority of individuals on forensic commitments in the Travis County jail are transferred directly to the SMHF for psychiatric treatment. In FY2011, the SMHF inpatient bed allocation for individuals on forensic commitments in Travis County accounted for 49 percent of all SMHF funding.

Target population: This project targets Medicaid eligible and/or indigent individuals with co-occurring substance use and mental health disorders experiencing a psychiatric crisis to provide appropriate, cost effective crisis treatment alternatives to hospitalization and incarceration. Currently, 38 percent of ATCIC's consumers have Medicaid and 62 percent are indigent. Because this project targets a similar Medicaid eligible and indigent population, ATCIC anticipates this target population will mirror the population primarily served by ATCIC.

Category 1 or 2 expected patient benefits: The goal of this project is to decrease preventable criminal system admissions and readmissions by 5 percent compared to baseline in DSRIP Year (DY) 4, and 10 percent compared to baseline in DY5. Improvement milestone/metric I-1.1 was selected to correspond with the RHP 7 goal to: (1) reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting, and (2) improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. It is anticipated that during DY3, 894 (duplicated) individuals will be served through this project.

Category 3 outcomes: One Category 3 standalone improvement target will be implemented for this project: 1) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. By expanding crisis residential capacity an opportunity is created to link individuals in psychiatric crisis to alternative community-based services and decrease Potentially Preventable Readmissions.

Title of Project: **Hospital and Jail Alternative Project: Crisis Residential Program, Development of behavioral health crisis stabilization services as alternatives to hospitalization**

Category / Project Area / Project Option: **2.13.1**

RHP Project Identification Number: **133542405.2.3 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description – This project will expand psychiatric crisis residential treatment services to augment Austin Travis County Integral Care's (ATCIC) existing psychiatric crisis continuum.

Crisis residential services are designed to provide short-term, community-based intensive psychiatric treatment for persons experiencing a psychiatric crisis that may pose some risk of harm to self or others and/or may have severe functional impairment. The proposed crisis residential program will specialize in providing psychiatric crisis care for individuals diagnosed with co-occurring substance use and mental health disorders. In addition, it will help meet the community's need for hospital and jail diversion treatment alternatives for individuals with co-occurring disorders. The Substance Abuse and Mental Health Services Administration's (SAMHSA) best practice recommendations emphasize the importance of providing integrated treatment such that substance use and mental health disorders are treated as primary diagnoses, in a coordinated manner and in the same setting by treatment experts for both disorders. These services will be located in downtown Austin at an existing 24 bed facility that is easily accessible and in close proximity to other city services, including two large homeless shelters and the city's largest emergency department (ED). By expanding psychiatric crisis residential capacity, alternative residential treatment options are created so that individuals experiencing a behavioral health crisis (e.g., an individual who is in immediate risk of harm to self or others due to a mental health condition) can receive appropriate, cost effective care.

Established in 1966, ATCIC serves as the local mental health authority for Travis County, with funds received from local, state and federal sources. ATCIC is responsible for providing the psychiatric crisis safety net for Travis County and managing the funding allocation of state mental health facility (SMHF) inpatient psychiatric beds. With 26 percent population growth in Travis County from 2000-2006 and a projected 7 percent growth rate through 2016, ATCIC anticipates an increased demand for the community's psychiatric crisis safety net services it provides *(RHP-7, CNA [draft], Central Health, Travis County, July 2012).* Already, Travis County's psychiatric inpatient capacity is strained. As of April 2012, Travis County was at 142 percent utilization of its SMHF inpatient psychiatric bed allocation and is currently using 100 percent of locally funded inpatient psychiatric beds for fiscal year FY2012. Wait times for individuals in psychiatric crisis in ED's averaged 15.63 hours in January 2012, representing a 39 percent increase from FY2011(Psychiatric Stakeholders Committee, 1/2012 report). By increasing crisis residential

treatment and system capacity, more individuals can be stabilized and supported in a community setting instead of high-cost facilities such as hospitals or jails due to lack of viable community alternative treatment options. Currently, 38 percent of ATCIC's consumers have Medicaid and 62 percent are indigent. Because this project targets a similar Medicaid eligible and indigent population, ATCIC anticipates this target population will mirror the population primarily served by ATCIC.

Currently there are no local *specialized* crisis residential treatment alternatives immediately accessible for Medicaid eligible and/or indigent individuals with co-occurring substance use and mental health disorders. The prevalence of behavioral health conditions among adults with a substance use diagnosis is approximately 43 percent *(RHP-7, CNA [draft], Central Health, Travis County, July 2012).* However, a nationally representative population study conducted by The National Comorbidity Study (Kessler et al., 1996), reports 41-65 percent of participants with any lifetime substance use disorder also had a lifetime history of at least one mental health disorder. Notably, in 2010, individuals with four or greater re-readmissions (within 30 days) for inpatient psychiatric hospitalization and numerous ED visits for psychiatric care were primarily individuals with co-occurring mood and substance use disorders who experience "literal homelessness" and untreated co-occurring disorders (Mayor's Mental Health Task Force Models for Change Report, 2011). In FY2010, the average inpatient cost per individual with four or greater re-readmissions (within 30 days) was $28,288 and the estimated cost of inpatient hospitalization was $368,000 (Mayor's Mental Health Task Force Models for Change Report, 2011), while the cost for a visit to the ED is an average of $1,265.00 (mhatexas.org). The American Psychological Association's (APA) best practices for psychiatric crisis services identifies crisis residential services as integral to a comprehensive and robust psychiatric crisis care continuum, noting that evidence suggests crisis respite and crisis residential services are as effective and much less expensive than hospital care (Allen, M., Forster, P., Zealberg, J., & Currier, G. (2002). *Report and recommendations regarding psychiatric emergency and crisis services: A review and model program descriptions.* APA Task Force on Psychiatric Emergency Services, August 2002). Crisis system capacity and community-based treatment alternatives that address the needs of individuals with co-occurring substance use and mental health disorders must be in place to achieve the "Triple Aim" of improved patient experience, outcomes and decreased cost.

Additionally, individuals with co-occurring disorders may be jailed due to the lack of readily accessible *jail diversion* community-based treatment alternatives for individuals with low-level charges who experience homelessness (Lamb, H.R., Weinberger, L.E., & DeCuir, W.J., (2002). The Police and Mental Health. *Psychiatric Services, 52*(10), 1266-1271). This practice is known as "mercy booking." Mercy booking may occur because there is a belief that people can more readily obtain treatment in jail than in the community. Regardless, this practice criminalizes mental illness. In FY2011, Travis County jail data showed that approximately 5 percent of individuals booked experienced severe and persistent mental illness and approximately 15 percent were identified to have a behavioral health disorder (Travis County Sheriff's Department, FY2011). Moreover, during FY2011 the average length of incarceration for an individual identified with a behavioral health disorder was 54 days, versus 17 days for individuals who were not identified with a behavioral health disorder (Travis County Sheriff's Department, FY2011). Treatment costs for a person with mental illness who is incarcerated averages $137.00 per day (mhatexas.org). Ironically, the majority of individuals placed on forensic commitments in the Travis County jail are transferred directly from the jail to the SMHF for psychiatric treatment. In FY2011, the SMHF inpatient bed allocation for individuals on forensic commitments in Travis County accounted for 49 percent of all SMHF funding expenditures. The lack of sufficient and availabile community-based jail diversion alternatives for indigent and/or Medicaid eligible individuals with mental illness and substance use disorders contributes to this inefficient use of scarce resources. In short, there is a pressing community need to provide individuals with co-occurring disorders the right service at the right time and right place.

The proposed crisis residential program will include services such as psychiatric screening and psychiatric crisis assessment, access to a prescriber and medications, 24-hour nursing care, intensive care management, linkage to on-going care and other resources, rehabilitative skills building and counseling to ensure the individual's immediate crisis is stabilized. Given the prevalence of co-occurring mental health and substance use disorders and the lack of existing specialized crisis residential treatment alternatives for Medicaid eligible and/or indigent population, the proposed crisis residential program represents a much needed community-based specialty treatment alternative for diverting potentially preventable behavioral health and criminal justice admissions and readmissions.

Project Goals - The goal of this proposed project is to decrease behavioral health (includes substance use) 30-day readmission rates and decrease preventable criminal system admissions and readmissions by 5 percent compared to baseline in DSRIP Year (DY) 4, and 10 percent compared to baseline in DY5. To achieve the Triple Aim of improved patient experience, decreased cost and improved outcomes, we propose creating crisis system capacity to address the needs of individuals with co-occurring substance use and mental health disorders by providing specialized crisis residential treatment. It is anticipated that by DY-3 approximately 894 (duplicated) individuals will receive services through this project.

Challenges or Issues Faced by the Performing Provider - This project targets individuals who may not have previously sought help from behavioral health providers. These "new" patients strain the capacity of an already burdened local behavioral health system. To meet this increase in demand, additional capacity is required in four key areas:

5. Access to prescribers
6. Mobile crisis behavioral health capacity to reach out to previously unidentified patients at the points they intersect local hospitals and criminal justice systems
7. Hotline staff to assess and triage crisis behavioral health referrals
8. Primary providers of routine specialty care behavioral health treatment services

The second set of challenges include developing effective planning and processes to ensure effective communication between ATCIC and the four community organizations responsible for central booking, police and the two independently operated ED's. Early efforts in collaboration with formal longstanding, multi-level community processes have started and set the stage in addressing this second challenge.

How the Project Addresses those Challenges - To meet the need for added behavioral health capacity, the following plans have been initiated:

5. Planning for adequate prescriber capacity: *included as part of this proposed project*
6. Expansion of mobile crisis behavioral health capacity that provide outreach to previously unidentified patients at strategic intercept points in local hospitals and the criminal justice systems): *currently proposed expanded MCOT project in RHP 7*
7. Expansion of hotline capacity to assess and triage referrals: *currently proposed expanded MCOT project in RHP 7*
8. Increasing access to primary providers for routine, community-based specialty behavioral health treatment services *currently proposed Dove Springs project in RHP 7 to link individuals with ongoing behavioral health treatment with integrated primary care*

Existing local planning efforts have already set the stage in addressing the second challenge. In 2007, Central Health convened a local Psychiatric Stakeholders Committee comprised of high-level representatives from law enforcement, local hospitals, ATCIC, Travis County and others. Concurrently, a

Crisis Intervention Committee (CIC) was meeting as a work group that reviewed mutually identified community measures, identified needs and gaps and proposed solutions for the larger stakeholder committee. These efforts have resulted in tangible healthcare improvements and investments in Travis County, including the allocation of $9 million for inpatient psychiatric care in FY 2012. At a hands-on level, ED social workers have met with ATCIC crisis employees on a quarterly to bi-quarterly basis for approximately five years to exchange information and address issues as they arise. Similarly, ATCIC crisis employees and local CIT law enforcement officers meet on a quarterly basis. Beginning February 2012, APD partnered with ATCIC, as the local behavioral health authority, to provide CIT officers and new recruits with training on mental health. These joint trainings are the fruit of several years of collaboration and bridge building. They are proving to be successful in furthering positive relationships with law enforcement. These existing collaborative relationships are the foundation for continued growth and development of ongoing formal and informal communication processes to ensure the success of this project.

How the Project is Related to RHP Goals - The six counties that comprise RHP Region 7 in Texas have identified seven RHP goals, five of which relate to this proposed project:

1. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
2. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
3. Bolster individual and population health by improving chronic disease management.
4. Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.
5. Improve the patient experience of care by increasing the quality of care and patient safety.

Starting Point/Baseline

Baseline Data

During FY2012, ATCIC's existing and well established 16 bed psychiatric crisis residential program served 894 duplicated individuals. Based on this data, proposed capacity and the normal anticipated and unanticipated challenges that arise with any new program, it is believed a specialized crisis residential program serving individuals with co-occurring substance use and mental health disorders will serve 894 duplicated individuals in DY3, the first year of the new program.

Rationale

Reason for Selection of Project Options and Components - With 26 percent population growth in Travis County from 2000-2006 and a projected seven percent growth rate through 2016, the demand on the community's psychiatric crisis safety-net will increase *(RHP-7, CNA, Central Health, Travis County, Sept. 2012).* This crisis residential project, which targets individuals with co-occurring substance use and mental health disorders experiencing a psychiatric crisis, was selected to ensure appropriate, cost effective treatment from specialized alternatives to hospitalization and incarceration. Providing specialized crisis residential capacity for individuals with co-occurring mental health and substance use disorders aims to: a). reduce the burden and costs on local emergency departments and increase both consumer and public safety by providing specialized behavioral health services; and b): provide behavioral health treatment alternatives to incarceration. Further, by targeting jail diversion alternatives, there is an opportunity to bring specialty behavioral health treatment that is appropriate and effective for minority populations who come into contact with law enforcement in disproportionate numbers. Achieving this goal addresses RHP

7 Community Needs Assessment that identifies the need to address the existing racial and ethnic disparities across health conditions and improve access to behavioral health care.

This project will be addressing all of the project components. The following project components will be completed: (a) assess size, characteristics and needs of target population: *size, characteristics and needs of the target population have been identified in this proposal and will continue to be assessed during DY2* (b) review literature and experiences similar to target populations to determine community-based interventions that are effective in averting negative outcomes: *literature and experiences similar to target populations will be reviewed and community based interventions that are effective in averting negative outcomes that have been identified in this proposal will be further refined during DY2* (c) develop project evaluation plan using qualitative and quantitative metrics to determine outcomes: *a project evaluation plan will be developed using qualitative and quantitative metrics to determine outcomes during DY2-DY3* (d) design models that include an appropriate range of community services and residential supports: *models will continue to be developed and designed that includes an appropriate range of community services and residential supports in DY2* and (e) assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population: *the impact of interventions will be assessed based on standardized quantitative measures and qualitative analysis relevant to the target population from DY3 through DY5*.

Reason for Selection of Milestones & Metrics - Process milestone/metric P-7 was selected to promote ongoing learning and exchanges between providers and collectively decide how to "raise the floor" for performance across all providers. Process milestone/metric P-3 was selected based on anticipated readiness to enroll and serve individuals with co-occurring mental health and substance use disorders in a specialty psychiatric crisis residential setting. Improvement milestone/metric I-1.1, Criminal Justice Admissions/Readmissions, was selected to correspond with the RHP 7 goal to: (1) reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting, and (2) improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

Community Need Identification Number: CN.1, CN.4, CN.6, CN.7, CN.8, CN.15, CN.16, CN.17

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative – ATCIC's current crisis residential program capacity is 16 beds. Adding 24 specialized co-occurring substance use and mental health crisis residential beds will increase capacity by 150 percent. During FY2012, ATCIC's existing and well established 16 bed psychiatric crisis residential program served 894 duplicated individuals.

Expanding crisis residential capacity will significantly enhance ATCIC's community-based behavioral health crisis continuum, that currently includes 24 hour Psychiatric Emergency Services, 24 hour American Association of Suicidology accredited hotline and national Lifeline services, 24 hour Mobile Crisis Outreach Team services, crisis residential services and crisis respite services. Approximately 23,520 duplicated individuals sought ATCIC's crisis services in FY2011.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) – None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected – OD-3: Potentially Preventable Re-Admissions. One Category 3 standalone improvement target will be implemented for this project: 1) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. Process milestones P-1, Project Planning (DY-2) and P-2, Establish Baseline Rates (DY-3) are the corresponding measures selected for Category 3 outcomes.

Reasons/Rationale for Selecting the Outcome Measure(s) - The Community Needs Assessment for RHP-7 reveals that Travis County experienced a 33 percent increase in inpatient hospitalizations from 2008 to 2010. For FY2012 year to date, readmission rate to inpatient psychiatric hospitals within 30 days is 14.4 percent, a two percent increase from FY2011 (Central Health, CIC, 9/12 Report). By expanding crisis residential capacity an opportunity is created to link individuals in psychiatric crisis to alternative community-based services and decrease Potentially Preventable Readmissions, or PPRs.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects - TBD

List of Related Category 1 & 2 Projects *(RHP Project ID Number)* - 133542405.2.1, 133542405.2.2, 01335424-05.2.14.1, 133542405.1.7, 133542405.1.9.3

List of Related Category 4 Projects *(RHP Project ID Number)* - N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

133542405.2.2: Mobile Crisis Outreach Team Expansion
133542405.1.2: Expand Specialty Behavioral Healthcare Prescriber Capacity
133542405.1.3: Introduce, Expand, or Enhance Telemedicine/Telehealth
126844305.1.2: Child Crisis Respite through Therapeutic Foster Care
126844305.2.1: Transitional Housing Guided by Peer Support
126844305.1.3: Outpatient Substance Addiction Services for Adult and Youth
126844305.2.2: ACT for IDD Population
126844305.2.3: Services for Justice-Involved Youth and Adults

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project - The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and cost reduction to the healthcare system. In considering the incentive portion of the valuation, three principles and their subsequent impacts were considered. These principles include: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to

the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing specialty co-occurring substance use and psychiatric crisis services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. The proposed crisis residential program will specialize in providing psychiatric crisis care for individuals diagnosed with co-occurring substance use and mental health disorders and will include services such as psychiatric screening and psychiatric crisis assessment, access to a prescriber and medications, 24-hour nursing care, intensive care management, linkage to on-going care and other resources, rehabilitative skills building and counseling to ensure the individual's immediate crisis is stabilized. Given the prevalence of co-occurring mental health and substance use disorders and the lack of existing specialized crisis residential treatment alternatives for this population, the proposed crisis residential program represents a much needed community based specialty alternative for diverting potentially preventable behavioral health and criminal justice admissions and readmissions.

Calculating the value of interventions for this project for a specialty behavioral health population was done using an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system. These individuals also frequently present with a number of functional impairments, which lead to involvement in the criminal justice system. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare and criminal justice systems.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.2.3	***2.13.1***	***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, emergency departments, urgent care etc.)***	
Austin Travis County Integral Care				***TPI:* 133542405**
Related Category 3 Outcome Measure(s):	***133542405.3.7***	***IT-3.8***	***IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-7: Participate in face-to-face learning (ie, 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 P-7.1: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. c. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes d. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 1 Estimated Incentive	**Milestone 2** P-7: Participate in face-to-face learning (ie, 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: P-7.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 2 Estimated Incentive		**Milestone 4** I-1: Criminal Justice Admissions/Readmissions Metric: I-1.1: 5% decrease in preventable admissions and readmissions into Criminal Justice System; a. Numerator: The number of individuals receiving crisis stabilization who had a potentially preventable readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period b. Denominator: The number of individuals receiving crisis stabilization. *This would be measured at specified time intervals throughout the project to determine if there was a decrease.* Data Source: Criminal justice system records, and data from local crisis stabilization sites. Rationale/Evidence: See project Goal Milestone 4 Estimated Incentive Payment: $2,133,918 **Milestone 5** P-7: Participate in face-to-face learning (ie, meetings or seminars at least twice	**Milestone 6** I-1: Criminal Justice Admissions/Readmissions Metric I-1.1: 10% decrease in preventable admissions and readmissions into Criminal Justice System; c. Numerator: The number of individuals receiving crisis stabilization who had a potentially preventable readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period d. Denominator: The number of individuals receiving crisis stabilization. *This would be measured at specified time intervals throughout the project to determine if there was a decrease.* Data Source: Criminal justice system records, and data from local crisis stabilization sites. Rationale/Evidence: See project Goal Milestone 6 Estimated Incentive Payment: $2,061,757 **Milestone 7** P-7: Participate in face-to-face learning (ie, meetings or seminars at least twice

133542405.2.3	***2.13.1***	***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, emergency departments, urgent care etc.)***	
Austin Travis County Integral Care				***TPI:* 133542405**
Related Category 3 Outcome Measure(s):	***133542405.3.7***	***IT-3.8***	***IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment: $3,633,010	Payment: $1,994,749 **<u>Milestone 3</u>** 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.) <u>Metric:</u> P-3.1. Metric: Number of targeted individuals enrolled/served in the project. Baseline/Goal: 894 (duplicated) individuals b. Project documentation Milestone 3 Estimated Incentive Payment: $1,994,750		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:</u> P-7.2: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. a. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the floor" for performance across all providers.	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 :</u> P-7.2: Implement the "raise the floor" improvement initiatives established at the semiannual meeting. c. 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. d. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchanges between providers and decide collectively how to "raise the floor" for performance across all providers.

133542405.2.3	***2.13.1***	***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, emergency departments, urgent care etc.)***	
Austin Travis County Integral Care				***TPI:*** **133542405**
Related Category 3 Outcome Measure(s):	***133542405.3.7***	***IT-3.8***	***IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 5 Estimated Incentive Payment: $2,133,918	Milestone 7 Estimated Incentive Payment: $2,061,757
Year 2 Estimated Milestone Bundle Amount: $3,633,010	Year 3 Estimated Milestone Bundle Amount: $3,989,499		Year 4 Estimated Milestone Bundle Amount: $4,267,836	Year 5 Estimated Milestone Bundle Amount:$4,123,514
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,013,859				

Austin Travis County Integral Care
Community Behavior Support (CBS) Team
Project Identifier: 133542405.2.4 Pass 2

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has been committed to providing services for children, families and adults with behavioral health disorders. In fiscal year 2011, more than 23,000 individuals and families received services from ATCIC, of who 10,000 were adults with serious mental illness (SMI). ATCIC is the Local Mental Health Authority for Travis County and Joint Commission accredited.

Intervention(s): This project will develop a community-based, crisis response team specializing in immediate care, intervention and stabilization for individuals with a co-occurring developmental disability and mental illness (DD/MI) diagnoses. Emergency departments (EDs), medical providers, jails and private providers are just some of the interception points the Community Behavior Supports (CBS) team will respond to. The goal of the team is to intercept and provide necessary services and supports to this targeted population in the most appropriate setting, avoiding costly and unnecessary stays in hospitals, jails, or be at risk for permanent removal from their current living environment.

Need for the project: Current systems of care do not adequately provide specialized support for individuals with co-occurring DD/MI diagnoses. As a result, they frequently bounce between EDs, law enforcement agencies, psychiatric hospitals and state supported living centers with little to no continuity and support necessary to sustain long-term success. The CBS team encompasses all necessary components beginning with initial evaluation and continuing care until a solid system of support is in place.

Target population: The target population for this project is individuals who have been identified with a dual diagnosis of DD/MI and are experiencing a crisis. The majority of requests for assistance currently come from EDs and psychiatric hospitals. Thirty-eight percent of people served by ATCIC receive Medicaid benefits and the remainder is indigent. Current data attempts to quantify the percentage of persons with intellectual disability and mental illness range from 20 to 71 percent. During calendar year 2012, 207 individuals with a DD, Autism, and or Asperger's diagnosis received at least one encounter from ATCIC's Mobile Crisis Outreach Team (MCOT) or Psychiatric Emergency Services (PES). Based on this data, we will establish our baseline at 50 (duplicated) individuals who meet criteria for CBS Team supports who are typically referred from private providers, EDs, or the criminal justice system.

Category 1 or 2 expected patient benefits: The project seeks to design specialized interventions based on results from a gap analysis, extensive literature review of existing evidence-based best practices, consultation with experts from other states who have been successful in implementing similar programming, and tailored interventions that address local need. Information gathered in DY2 and DY3 will guide development and initiation of first services and intervention beginning in DY4. We will expand the percentage and number of individuals served each year between DY 4 and DY 5 from five to ten percent. Individuals will succeed in our community in the least restrictive environment through this team based approach.

Category 3 outcomes: IT 9.2- Our goal is to ensure appropriate ED utilization and reduce all psychiatric ED visits for this targeted population. The goal is to increase five percent in population reached by DY 4 and 10 percent by DY 5. The goal is to increase five percent in population reached by DY4 and ten percent by DY 5. The baselines will be revised, as needed in DY 2.

Title of Project: **Community Behavior Support (CBS) Team**

Category / Project Area / Project Option: **2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population**

RHP Project Identification Number: **133542405.2.4 PASS 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description - Austin Travis County Integral Care (ATCIC) proposes the creation of a Community Behavior Support (CBS) Team that specializes in providing complex treatment in appropriate settings for people who have a co-occurring diagnosis of a developmental disability (DD) and mental illness (MI) or mental health disorder who meet the criteria defined in the Diagnostic and Statistical Manual – Fourth Addition. Individuals with co-occurring DD/MI diagnosis is not a new phenomenon, but it has received much more attention in recent years due to the process of deinstitutionalization combined with limited psychiatric inpatient availability. The CBS Team uses a team-planning approach to meet the unique needs of these individuals who are potentially an imminent harm to themselves or others by providing them with immediate specialized care, evaluation, stabilization or treatment. A person centered-plan is developed through a collaborative, team-planning process that involves all members of the CBT Team and others who are relevant to the individuals' success. The team collaborates to develop and implement the person centered, individualized plan of care.

The proposed CBS Team consists of a psychiatrist with proven experience with the IDD population, licensed behavioral psychologist (who is also the program director), registered nurse, support and behavior specialists. The core team will be appropriately staffed, but also requires a combination of full time, part-time, on-call and contract positions in order to maintain 24/7 operations. The psychologist must have a doctorate degree, be a licensed board certified behavior analyst and experience in:

- Scientific-based practices to conduct functional behavior assessments
- Working with individuals who have a co-occurring diagnosis of DD and MI
- Evaluating the organic components of an individual's behaviors
- Prescribing, monitoring and evaluating appropriate medications in conjunctions with a psychosocial intervention plan and
- In-patient state psychiatric hospital commitment procedures.

The registered nurse (RN) must have experience working with individuals who have co-occurring diagnoses of DD and MI and supporting people with multiple needs, including medical. The RN would be the clinical liaison and consultant between the team and other medical support staff involved in the individual's treatment.

Support specialists must have at least five years of direct care experience implementing behavior supports and skills training as designed by the team. The support specialists will assist with implementation of behavior intervention strategies, safety plans and/or behavior plans. They also provide one-to-one support, which may include assisting with environmental adaptations, coordinating additional, non-CBS services, or accompanying individuals to crisis response and follow-up appointments.

The behavioral specialists are required to have experience working with people who have co-occurring disorders. The behavior specialists will be required to be Board Certified Behavior Analysts (BCBA). Their role includes providing assistance, training and intervention, modeling with families or providers. They work closely with the psychiatrist and psychologist to monitor the individual's progress and immediately notify the team when they identify the need to revise or change identified supports.

The CBS Team will provide services that include, but are not limited to:

- Initial assessment and triage with on-site resolution as possible
- Coordination for immediate clinically appropriate services
- Coordination of community services to ameliorate crisis
- Short-term, clinical out-of-home respite
- Caregiver training
- Discharge planning and training
- Consultation and linkage to services at ATCIC and other community-based healthcare providers
- Nursing Assessments(s), recommendations for medical-nursing care and follow-up
- In-home applied behavior analysis training for families
- Counseling
- Functional Behavior Analysis, development of behavior intervention plan
- Psychiatrist and Medication Support

Since 1966, ATCIC has been committed to providing services for children, families and adults with behavioral health disorders. In fiscal year 2012, more than 23,000 individuals and families received services from ATCIC, of who 10,000 were adults with serious mental illness. ATCIC is the Local Mental Health Authority for Travis County and Joint Commission accredited. This opportunity will expand the scope of ATCIC's existing services and the ability to support individuals with this targeted need in our community.

Project Goals

The CBS Team will provide crisis prevention, intervention and stabilization for this population in the most integrated and appropriate settings based on an individual's needs. The CBS team will achieve this by developing adequate community-based supports that prevent involvement with criminal justice systems, institutionalization, hospitalization, homelessness, or in some cases - death. Current systems are ineffective for this targeted population. These prevention and intervention services effectively work to stop these trends. By providing a range from in-home supports to 24/7 crisis services in the natural living environment as an alternative to psychiatric and/or state institutionalization, the CBS Teams can:

- *Prevent* the person in crisis from harming themselves or others, by responding immediately and coordinating temporary clinical out of home respite to allow time for the team to design a person centered action plan.
- *Intervene* and provide de-escalation services at the location of the crisis, by providing on-site behavior support and support staff in the home if needed until the immediate crisis has subsided.
- *Stabilize* individuals experiencing a crisis to avoid more costly, ineffective and restricting alternatives while creating an atmosphere of safety at the site of the crisis by collaboratively developing a plan that includes all the necessary supports both in home and out of home.

During DY 2 the project goals include completing a gap analysis, literature review for evidence-based practices, and tailoring interventions to local needs and context needs assessment and implementing

subsequent program adjustments to the design and implementation plan. In our experience this population waits in emergency departments (ED) between one to 10 days after they are ready for discharge while social workers and nurses coordinate continuity and appropriate care. The CBS Team's work will decrease the length of time a person with co-occurring DD/MI is in an ED awaiting appropriate care or at risk of alternative and institutionalized care options. Additionally, the team will strive to demonstrate improved behavioral functioning for people who receives services 30 days following completion of the intervention.

Challenges or Issues Faced by the Performing Provider –

1) There have been disagreements over diagnostic validity, diagnostic overshadowing as well as significant variance in settings when it comes to determining the number of persons with a co-occurring IDD/MI diagnoses. One challenge arises from a "primary diagnosis" requirement in the DD and MI reporting and funding systems. Once a primary diagnosis has been designated, reporting and data tracking can be a challenge since there is no certainty that another diagnosis (known as secondary diagnosis) exist or has been omitted. Additionally, this reporting can impose a false need to serve in one system or the other, making it difficult to provide effective and integrated treatment for both diagnoses.
2) An additional challenge for all of Travis County is the reductions in the number of beds available in state operated psychiatric hospitals. These reductions have made admission criteria increasingly restrictive and counterproductive while ATCIC simultaneously pursues the development of home and community-based services. Community providers and families have recently become accustomed to seeking crisis intervention services through the ED or law enforcement. In such situations, the outcome is generally hospitalization, incarceration or institutionalization. These interventions alleviate the immediate symptoms, but generally do not have a long-term effect on the individual's behavioral functioning and do not guarantee a referral to our agency for ongoing support and necessary for prevention. The current service system that provides services for people with co-occurring diagnosis is fragmented and limited in its capacity to meet their needs and presenting issues.
3) Further, the combination of the limited pool of available community providers and the inadequate expertise they have in treating the needs of this targeted population, yield a woeful system of care of these specialized community-based services. As a result, individuals with co-occurring diagnosis frequently bounce between ED's, law enforcement agencies, public and state psychiatric hospitals and supported living centers with little or no continuity of care. This results in costly inpatient interventions that lack efficacy and fail to meet their long-term needs.

How the Project Addresses those Challenges –

1) By providing services to people who are in critical need when they need it, regardless of a primary diagnosis, the CBS Team can comprehensively and accurately capture their diagnosis and needs. We will work with partnering entities and intercept points to develop the best integrated data system which will capture all diagnosis and allow us to review and trend all needs. By providing services to people who are in critical need when they need it, regardless of a primary or secondary diagnosis, the CBS Team can comprehensively and accurately capture their diagnosis and needs. We will work with partnering entities and intercept points to develop the best integrated data system which will capture all diagnosis and allow us a new opportunity to review and trend all of the needs.
2) The CBS Team is designed to provide intense, on-call and immediate intervention for law enforcement, EDs and other service providers as needed, with the continuity of care needed to ensure success.

3) In addition, the CBS Team maximizes resources by providing specialized DD/MI training to physicians, on-site psychiatric consults for ED's, specialized advocacy for individuals in psychiatric emergencies and specialized training for police and other law enforcement officers.

Program outcomes include reducing the wait time in local EDs for appropriate services and increasing the number of individuals demonstrating stability in the community after receiving CBS Teams services, further decreasing ED wait time.

How the Project is Related to RHP- This project relates to Region 7's RHP by addressing the unmet treatment needs for people experiencing psychiatric crisis and building resources in less costly and restrictive settings. It also provides much needed access to care for people with IDD and co-occurring MI and/or serious behavioral challenges, who are often underserved. This project also reduces health system costs by expanding access to appropriate care in the most appropriate setting for patients and families.

Starting Point/Baseline

Baseline Data-Presently there is no clinical program dedicated to providing targeted psychiatric services and behavior supports to people with co-occurring DD and MI in Travis County which poses a dilemma to determining a baseline. Based on ATCIC service data, at least 207 individuals who meet diagnostic criteria for IDD services had a minimum of one encounter from MCOT or PES in calendar year 2012. Further, we know that similar interventions teams such as ACT or MCOT provide an average of 3.6 hours of services per individual, per week. However, because the CBS Team interventions will be more intensive, we estimate they will provide a minimum 6 hours per person on a weekly basis. Data on the number of individuals with co-occurring MI and IDD who utilize ED's and the length of time they are there is being collected in the current fiscal year. The baseline is established at 50 and we will use data collected during DY 2 to make revisions as needed.

Time Period for Baseline: Baseline data will be collected during DY 2.

Rationale

Reason for Selection of Project Options and Components - It is estimated that 11,000 individuals are diagnosed with IDD in Travis County, approximately one percent of the total population of which it is estimated that 30-50 percent have a co-occurring diagnosis of IDD and MI which is approximately 3,300-5,500 individuals who can benefit from targeted behavioral health services provided by the proposed CBS Team. ATCIC serves approximately 2,500 unduplicated individuals in a given year with an IDD (not including people with a co-occurring MI diagnosis). ATCIC service delivery data shows that over 200 individuals with an IDD diagnosis also received an intervention from other psychiatric emergency services. These individuals were referred by EDs, criminal justice system, family members, or private providers. These individuals will be served more effectively by interventions offered by the CBS Team.

There is a growing need in US and Travis County for these specialized services as our population continues to grow and resources continue to dwindle. The National Association for Persons with Developmental Disabilities (NADD) continues studies on best practices for the growing number of persons with IDD and MH needs. There are evidence-based best practices that support collaboration between specialized teams and primary caregivers works to effectively deescalate crisis situations and prevent problems in the future (Joan B. Beasley, Ph.D. "Planned Clinical Respite Services for Individuals with Intellectual Disabilities/Mental Illness and Their Families "NADD U.S. Policy Update. NADD Bulletin Vol. 12 #3. UNH Institute on Disability. 23 August, 2012. http://thenadd.org).

The movement towards community-based services and away from state institutional living compounds this challenge, as it requires serving more people with specialized needs in a community with the same dwindling resources. Between 2004 and 2009, approximately 252 people in State Supported Living Centers (SSLC) were successfully transitioned to the community. ATCIC is responsible for developing and ensuring adequate community-based supports exist and address the needs of people who may otherwise be at-risk of institutionalization or re-institutionalization. Unfortunately, the rate of referrals and placements from state institutions to the local community has reduced to just a few each year. The state institutions are required to determine if "barriers" exist which would pose a challenge for successful placements in the community; and among them often listed is lack of adequate supports to meet multiple needs especially for people with severe behavior challenges. There are more than 300 individuals currently residing at Austin SSLC and 40 individuals who are being assisted to successfully move back into the community, with more community referrals expected in the upcoming years, all of which will have Medicaid. It is estimated nearly two-thirds of the SSLC population in Texas has a dual diagnosis DD/MI, meaning that Austin SSLC has approximately more than 100 people who need specialized support for successful placement in the community.

The CBS team will meet the needs of our community and serve individuals already residing in our community as well as those who voice their desire to return to our community and leave institutional settings. Necessary components which will contribute to the overall success and impact of CBS Team interventions will include:

a) **Assess size, characteristics and needs of target population.** ATCIC currently serves over 750 individuals with co-occurring IDD/MI diagnosis and could benefit from the interventions of the CBS Team. We estimate that there are more than 3,300 people currently in the community who also meet the diagnostic criteria and could benefit from a specialized, wrap-around crisis and stabilization intervention. In addition, approximately 100 individuals currently residing at the Austin State Supported Living Center have an opportunity to move into community-based care settings if these intensive supports existed. Efforts in DY2 to review trends of people who seek care in inappropriate settings will help with program design. ATCIC will also identify and examine the most significant needs required to sustain the person in the least-restrictive environment.
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.** While there are few national models that target this specific population, they do exist. Thus far, success reported include preventing inpatient hospitalization, improved outcomes, reducing and eliminating the need for return to an institutional setting, etc. ATCIC will research and incorporate best practices from these programs and opportunities into the CBT Team program.
c) **Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.** A design such as the CMS Quality Framework for Home and Community Based Services will be used for the project evaluation plan. The framework includes several quality domains and associated sub-domains including: participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction, and system design and performance.
d) **Design models which include an appropriate range of community-based services and residential supports.** The CBS Team is committed to achieving and maintaining community-based living service options. The program design features built-in flexibility that allows for

program expansion where appropriate. At a minimum, services will include: specialized behavior therapies, transportation to appointments and community-based activities, medication support, short-term respite care, community-based nursing and in-home training and education.

e) **Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.** ATCIC will implement quality reviews to produce findings, considerations and recommendations as "lessons learned" that will be studied by all team members. Functional Behavior Analysis will be completed upon enrollment into CBS Team services and at designated intervals to track progress and trends. This also guides program changes and expansion to a broader group of people with similar needs who could benefit from these services.

Reason for Selection of Milestones & Metrics - The CBS Team will be a new concept and approach to serving the DD/MI population in our community. Process Milestone/metric P-X was selected so that a tailored intervention strategy can be developed based on local needs. ATCIC has engaged in conversations with other local providers and various stakeholders who voice concerns over shared experiences and challenges in serving this targeted population. We are confident that this shared desire to better serve this target population will serve as the foundation to begin working collaboratively towards improvement and targets. The CBS Team, will enforce the rationale used to select process milestone/ metric P-7 and P-2. Collaboration between the IDD, MH, and healthcare systems need improvement, it is apparent there exist a network of providers in the field who would be committed to working collaboratively, openly and honestly toward solutions.

Unique Community Need Identification Number: CN.2, CN.4, CN.6, CN.7, CN.8, CN.15, CN.16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative: A careful assessment of the history of services for people with DD and significant behavioral/psychiatric problems shows that the delivery system has not been effective to serve individuals with co-occurring conditions. Through this project, The CBS Team will address the complexity of affected individuals, particularly on the multiplicity of etiology of their problems, then work together with consumers, their families and other providers to help achieve success.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS): None

Related Category 3 Outcome Measure(s)

***Category 3 Outcome Measures(s) Selected* – OD-9: Right Care, Right Setting.** One Category 3 standalone improvement target will be implemented for this project under the category outcome Right Care, Right Setting: 1) IT-9.2: ED appropriate utilization. Process milestones P-7 program planning and P-2.1 Establish baseline rates

Reasons/Rationale for Selecting the Outcome Measure(s) - As referenced in the *The Community Needs Assessment*, completed by Region 7 does not have a dedicated psychiatric emergency room, forcing patients to seek care at local hospital ED's that are not staffed or designed to treat people experiencing a psychiatric crisis — much less individuals with co-occurring IDD and MI. The shortage of inpatient beds compounds this problem. This proposed project will bring all the necessary health systems together by implementing collaborative continuity processes which affectively address these complex challenges resulting in the most appropriate referral and care.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects:

List of Related Category 1 & 2 Projects *(RHP Project ID Number):* 133542405.1.9.3, 133542405.1.1

List of Related Category 4 Projects *(RHP Project ID Number)*: N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

137265806.1.1: Psychiatric Emergency Department
307459301.2.6: Community Paramedic Patient Navigation Program
126844305.2.2: ACT for IDD Population
133340307.2.2: Intellectual & Developmental Disability Crisis Center

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects – Region-wide, anchor-led meetings will be held at least semi-annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaborative that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project – ATCIC Waiver projects approached valuation considering three primary elements: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. Consideration in determining the incentive portion of the valuation included three principles and their subsequent impacts including; investments required to initiative the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement; and incentives to the performing provider to accelerate transformation of delivery system.

This project specifically addresses the ability to provide crisis prevention, intervention, and stabilization for this population in the most integrated and appropriate settings based on an individual's needs. The CBS Team will achieve this by developing adequate community-based supports that prevent involvement with criminal justice systems, institutionalization, hospitalization, homelessness, or in some cases – death.

This valuation for this targeted intervention was completed using an economic evaluation model, performed by a medical economist. This model uses cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com. Current systems are ineffective for this targeted population. The interventions described within this program design work to reduce trends and positively impact our regions' health care delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.2.4	2.13	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population - Community Behavior Support (CBS) Team
Austin Travis County Integral Care			133542405
Related Category 3 Outcome Measure(s):	133542405.9.2	IT-9.2	ED Appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-X Conduct gap analysis of current systems which exist to support targeted population. <u>Metric 1</u> P-X.1. Conduct gap analysis, literature review for evidence-based practices and tailor intervention to local context. Baseline/Goal: Baseline is 50 based on existing data. A challenge exists to quantify the target population. Data will be collected in DY 2 and select interventions to be developed for target population as necessary. Data Source: findings report from analysis and review of best practices. Milestone 1 Estimated Incentive Payment: *$489,535* **Milestone 2** P-2: Design community-based specialized interventions for target populations. Interventions may include (but are not limited to) Residential Assistance, Foster/ Companion Care, supervised Living, Residential Support Services, Respite) <u>Metric 1</u> P-2.1: Project plans which are based on	**Milestone 3** P-7: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. 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</u> P-7.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Complete at least two annual face-to-face meetings or seminars organized by the RHP Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,075,141	**Milestone 4** I-X.1 Increase percentage of target population reached. <u>Metric 1</u> Goal: Increase by 5% over baseline. Data Source: EHR and ED records Milestone 4 Estimated Incentive Payment: $1,150,150	**Milestone 5** I-X.1 Increase percentage of target population reached through program. <u>Metric 1</u> Goal: Increase by 10% over baseline DY 2-4. Data Source: EHR and ED records Milestone 5 Estimated Incentive Payment: $1,111,257

133542405.2.4	2.13	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population - Community Behavior Support (CBS) Team
Austin Travis County Integral Care			133542405
Related Category 3 Outcome Measure(s):	133542405.9.2	IT-9.2	ED Appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
evidence/experience and which address the project goals Baseline/Goal: Project documentation and final operational plan. Data Source: Project Documentation Milestone 2 Estimated Incentive Payment: $489,535			
Year 2 Estimated Milestone Bundle Amount*:* $979,070	Year 3 Estimated Milestone Bundle Amount: $1,075,141	Year 4 Estimated Milestone Bundle Amount: $1,150,150	Year 5 Estimated Milestone Bundle Amount: $1,111,257
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $4,315,618			

Austin Travis County Integral Care
Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults
Project Identifier: 133542405.2.5 Pass 2

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has been committed to providing services for children, families and adults with behavioral health disorders. In fiscal year 2011, more than 23,000 individuals and families received services from ATCIC, of who 10,000 were adults with Serious Mental Illness (SMI). ATCIC is the Local Mental Health Authority for Travis County and Joint Commission accredited.

Intervention(s): This project will implement evidence-based health promotion programming for adults with (SMI) in chronic disease management. Individuals will learn and understand how to self-manage their chronic disease conditions.

Need for the project: There is a profound disparity in life expectancy for persons with SMI. The latest studies indicate they die 25 years sooner than the rest of the population. This reduction in life expectancy for persons with SMI surpasses the reduction in life expectancy for most racial or ethnic groups due to health disparities. The five percent of Americans who have SMI die of the same chronic disease conditions as the rest of the population — lung cancer, heart disease, stroke, pulmonary disease and diabetes, only at much higher rates. Persons with a serious mental illness are more than twice as likely to smoke cigarettes (they smoke 44 percent of all US produced cigarettes) and more than 50 percent more likely to be obese compared to the rest of the population. People with major depressive disorder are at higher risk for cardiovascular disease and stroke.

Target population: The target population is adults with SMI who are identified with chronic disease conditions through medical records, assessment and health risk assessments.

Category 1 or 2 expected patient benefits: This project seeks to enroll 400 adults with SMI who are identified to have a chronic disease condition. Individuals will receive information and assistance to self-manage their conditions, thus improving their health and functional status.

Category 3 outcomes: OD-6, IT 6.1: Patient Satisfaction Scores. This project seeks to establish higher patient satisfaction scores over baseline with enrolled persons health/functional status. The goal is a 25 percent improvement over baseline.

Title of Project: **Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults**

Category / Project Area / Project Option: **2.14.1 – Establish interventions to promote person-centered wellness self-management strategies and train staff/contractors to empower consumers to take charge of their own health care**

RHP Project Identification Number: **133542405.2.5 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description - Austin Travis Integral Care (ATCIC) proposes this project to targets people with Serious Mental Illness (SMI), a population with elevated rates of chronic disease conditions by specifically addressing the elevated chronic disease concerns within the SMI population. The implementation of the following Substance Abuse and Mental Health Services Administration (SAMHSA) best practice/evidence-based chronic disease care programs represent a constellation of programs that include Health Navigator, HEAL (Healthy Eating Active Living), InShape (Individual Self Health Action Empowerment Plan) and tobacco cessation programming that would be fitted to enrolled people with SMI, based on need determined by health-risk assessment results.

Since 1966, Austin Travis County Integral Care (ATCIC) has been committed to serve children, families and adults with behavioral health disorders. ATCIC is the Local Mental Health Authority (LMHA) for Travis County and carries out its mission with funding from a variety of grants and local, state and federal sources. ATCIC is Joint Commission accredited and provides the following services: behavioral health to adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED), intellectual and developmental disabilities, and psychiatric crisis services. In fiscal year 2011, ATCIC served more than 23,000 individuals and families, of who 10,000 were adults with SMI.

There is a profound disparity in life expectancy for those with SMI. The latest studies indicate that they die 25 years sooner than the rest of the population.[(2)] In fact, this reduction in life expectancy for adults with SMI surpasses the reduction in life expectancy for most racial or ethnic groups due to health disparities. While disorders such as schizophrenia, major depression and bipolar disorder are considered risk factors for suicide, most people with SMI do not die by suicide.[(3)(10)] Rather, the five percent of Americans who have SMI die of the same chronic disease conditions as the rest of the population — lung cancer, heart disease, stroke, pulmonary disease and diabetes, only at much higher rates.[(4)(11)] People with a serious mental illness are more than twice as likely to smoke cigarettes (they smoke 44 percent of all US produced cigarettes) and more than 50 percent more likely to be obese compared to the rest of the population.[(7)] People with major depressive disorder are at higher risk for cardiovascular disease and stroke.[(8)(9)]

ATCIC has adopted successful integrated behavioral and primary health care models that improve health outcomes for people with mental illness. The next logical and needed step is to identify, treat and improve the health of those ATCIC consumers with both SMI and chronic disease conditions. This project requires that ATCIC staff receive training in all aspects of chronic disease management for SMI populations: identification, assessment, motivational interviewing, referral, engagement and follow-up. Putting this

knowledge into practice, ATCIC staff will identify those SMI consumers who smoke, have diabetes, are obese, and that have inactive lifestyles. Using motivational interviewing techniques, staff will engage them with the appropriate specialists in the program components for individual planning, coaching and education as well as long-term monitoring.

The health promotion programming in chronic disease management, healthy eating, active living and smoking cessation will serve a cohort of SMI consumers with complex chronic disease conditions (smoking, obesity, elevated cholesterol, diabetes, inactivity and poor nutrition) in a multi-program model of intensive case management, intervention and education supplemented by experts in exercise, nutrition, smoking cessation and chronic disease management. The staff will provide highly individualized consultation, pro-active education, coaching and self-management instruction (e.g. groups, peer education, and health coaching). Staffing will include a dietician, certified tobacco and exercise specialists, chronic disease specialists and care managers. Using data from the EHR, hospitalizations, pharmacy, disease registry, the scheduling system and primary care provider consultations, ATCIC will create systems to identify and enroll consumers that will benefit from the multi-component model.

Project Goals: To implement multi-component, evidence-based health promotion programming in chronic disease management for adults with SMI as follows: Health Navigator, HEAL (Healthy Eating Active Living), InShape (Individual Self Health Action Empowerment Plan) and Tobacco Cessation. This will allow persons with SMI to better understand their disease and how to manage it, and in the longer term, see reductions in health indicators (weight, cholesterol, etc.).

Collectively, these program components provide coordinated care to consumers with SMI that have complex chronic medical and psycho-social conditions (e.g., mental illness, multiple chronic medical conditions) which require intensive care management and special interventions to optimize consumer health and healthcare utilization.

The four-year target goals establish multi-component programming that serve at least 400 consumers with SMI who need intensive care coordination and interdisciplinary chronic disease care resources by the end of Demonstration year (DY) 5, to reduce the number of SMI consumers who smoke, who are obese and to increase the number of SMI consumers who have a regular program of activity. ATCIC will serve 50 consumers in DY2, 75 consumers in DY3, 125 consumers in DY4, and 150 consumers in DY5. Taken together, these programs will reduce rates of hospitalization for chronic disease conditions, lower overall health costs both in the hospital and the outpatient setting and make behavioral health interventions more effective.

Challenges or Issues Faced by the Performing Provider

ATCIC has long realized that chronic disease management is a critical component of treating people with SMI. With limited resources, the primary focus in Travis County and across Texas has been on the integrated physical and behavioral health model, which does not take into account the complexity of chronic disease management for people with SMI.

How the Project Addresses those Challenges

Once launched, one of the keys to the success of the multi-component model will be to ensure long-term and intensive follow-up services. Research indicates that the longer and more intensive the follow-up, the more successful the interventions are in achieving program goals: tobacco cessation, improved diet and continued exercise, and reduction of elevated blood sugar and cholesterol levels.[5] It will also be important

to ensure that the participating psychiatrists understand the necessary changes in prescribing of psychotropic medications for consumers in the program.[6]

How the Project is Related to Region 7 Goals-
This project relates to Region 7's goals as follows:
Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems;

Goal 4: Bolster individual and population health by improving chronic disease management; and

Goal 5: Support prevention education and healthy lifestyles to improve population health by addressing the unmet treatment needs for persons with SMI who also have co-morbid chronic diseases and are receiving integrated care. The project addresses the dietary, obesity, activity level, smoking needs of the approximate 40 percent of those persons with SMI who have attendant chronic diseases.

Starting Point/Baseline

Baseline Data- Currently, ATCIC serves approximately 7,500 adults with Serious Mental Illness (SMI) every year in its various outpatient programs at more than 15 locations in Travis County. These adults enter ATCIC's system of care through a variety of entry points, including the justice system, hospitals, family- and self-referrals and various state and community agencies. Available services include outpatient counseling, pharmacotherapy, peer support, substance use counseling and housing assistance. Given the prevalence of chronic disease conditions, the addition of an integrated chronic disease management program would provide benefit to many of the 7,500 adults with SMI. ATCIC is in the beginning stages of fully developing a variety of health promotion and prevention programming. A baseline assessment will be conducted by collecting and analyzing data from ATCIC's EHR to establish prevalence of chronic disease conditions. Additionally ATCIC will administer a Health Risk Assessment (HRA) developed especially for populations with SMI by the CDC. A synthesis of the two databases will yield a population for whom these interventions will be directed.

Time Period for Baseline: Since this is a new program, baseline data will be collected during DY 2/3.

Rationale

Reason for Selection of Project Options and Components - At ATCIC, many of the consumers who need intensive care coordination have SMI and chronic illnesses and complicated psychosocial presentations. Having a multi-component model that addresses their individual needs and offer consumers the coaching and support needed will greatly increase the chances that their treatment will be more successful. Implementing the components listed below will yield a comprehensive set of programming interventions that promote person-centered wellness self-management of chronic disease conditions and empower persons with SMI to take charge of their own healthcare.

a) Develop screening process for project inclusion,
b) Identify population for intervention using EHR and encounter data, clinical records, or provider referrals,
c) Recruit eligible individuals based on administrative and diagnostic data,
d) Establish interventions and train staff and contractors,
e) Hire staff (including the following minimum qualifications):

- Wellness and Health Navigation: Bachelors level professional with experience in mental health and/or wellness initiatives or a peer specialist who has successfully completed the DSHS certification program for peer specialists;
- WRAP Facilitator: an individual trained and credentialed as a WRAP facilitator using the WRAP model developed by Mary Ellen Copeland; and
- WHAM certified peer specialists(SAMHSA trained Whole Health Action Management)

f) Train staff in motivational interviewing and person-centered planning, and
g) Assess project outcomes and conduct quality improvement (QI) using a variety of QI methods

Reason for Selection of Milestones & Metrics - Process Milestones/metrics P1, P2, P3, P4, P9, P10 and P13 were selected because they best fit the required steps in bringing up a chronic disease management program with the population of persons with SMI that ATCIC serves. The milestones/metrics have to do with establishing baseline, developing databases, hiring and training staff and ongoing evaluation of the delivery of 4 interlocking best practice chronic disease management programs (CDM).

Unique Community Need Identification Number: CN.6, CN.9, CN.10, CN.11, CN.12, CN.15, and CN.17

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative: ATCIC has been a leader in Texas in the delivery of integrated behavioral healthcare. The CDM programming that will be delivered through this project will greatly expand and target services to consumers with identified chronic diseases using a CDC developed tool for SMI populations.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS): None

Related Category 3 Outcome Measure(s)

***Category 3 Outcome Measures(s) Selected* – OD-6: Patient Satisfaction.** One Category 3 standalone improvement target will be implemented for this project under the category outcome Patient Satisfaction: IT-6.1(5) Percent improvement over baseline of patient satisfaction scores for patient's overall health/functional status using the CG-CAHPS Survey.

***Reasons/Rationale for Selecting the Outcome Measure(s)* – IT-6.1** is one of the allowable outcome measures under category 2.14 Wellness and can be administered pre- and post-delivery of services to identified persons with SMI who have also been identified as having chronic diseases. The programming specifically is aimed at producing sufficient change in enrollees so that they will be able to determine whether a health/functional status change has occurred for them.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects:

List of Related Category 1 & 2 Projects *(RHP Project ID Number):* 133542405.2.1, 133542405.1.1

List of Related Category 4 Projects *(RHP Project ID Number)*: TBD

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects
126844305.2.4: Behavioral Health Care Integration Clinic – Caldwell County
133340307.2.1: Expansion of Community Diabetes Project
307459301.2.2: Chronic Care Management Model for Individuals with Multiple Chronic Conditions
307459301.2.3: Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients
137265806.2.4: Behavioral Health Assessment and Resource Navigation
307459301.1.3: Mobile Primary Care
137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects – Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project – Calculating the value of interventions for this project for a specialty behavioral health population (adults with SMI and concurrent chronic disease) used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This valuation used cost-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., hospital admissions for chronic disease conditions are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com. The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI and chronic disease are intensive users of the healthcare system at rates much higher than the non-SMI population and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

References:

(1) Kochanek KD, Xu JQ, Murphy SL, et al. Deaths: Preliminary data for 2009. National vital statistics reports; vol 59 no 4. Hyattsville, MD: National Center for Health Statistics. 2011.

(2) Mauer B. Morbidity and mortality in people with serious mental illness. Parks J, Svendsen D, Singer P, Foti ME, editors. 2006. Alexandria, VA, National Association of State Mental Health Program Directors (NASMHPD) Medical Director Council. Ref Type: Serial (Book, Monograph)

(3) Mauer B. Morbidity and mortality in people with serious mental illness. Parks J, Svendsen D, Singer P, Foti ME, editors. 2006. Alexandria, VA, National Association of State Mental Health Program Directors (NASMHPD) Medical Director Council. Ref Type: Serial (Book,Monograph)

(4) Osborn DP, Levy G, Nazareth I, Petersen I, Islam A, King MB. Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the United Kingdom's General Practice Rsearch Database. *Arch Gen Psychiatry* 2007;64:242-249.

(5) Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis* 2006;3:A42.

(6) Essenmacher C, Karvonen-Gutierrez C, Lynch-Sauer J, Duffy SA. Staff's attitudes toward the delivery of tobacco cessation services in a primarily psychiatric Veterans Affairs hospital. *Arch Psychiatr Nurs* 2009;23:231-242.

(7) Shrestha L. CRS Report to Congress: Life Expectancy in the United States. August 6, 2006.

(8) Compton MT, Daumit GL, Druss BG. Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: a preventive perspective. Harv Rev Psychiatry. 2006 Jul-Aug;14(4):212-22.

(9) Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun;49(6):599-604.

(10) Pan A, et al. Depression and incident stroke in women. Stroke. Published online ahead of print Aug 11, 2011.

(11) Aron, R. Honberg, K. Duckworth et al. *Grading the States 2009: A report on America's health care system for adults with serious mental illness.* Arlington, VA: National Alliance on Mental Illness; 2009.

(12) NREPP--- SAMSHA's National Registry of Evidence-based Programs and Practices

(13) Anderson, D & Staufacker, M. (1996). The Impact of Worksite-based Health Risk Appraisal on Health-related Outcomes: A Review of the Literature. *American Journal of Health Promotion,* 10(6), 499–508.

(14) http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/health_risk_appraisals.htm

(15) http://www.samhsa.gov/data/2k12/NSDUH103/SR103AdultsAMI2012.htm

133542405.2.5	2.14.1	2.14.1A-G	Implementation of Chronic Disease Prevention/ Management Program	
Austin Travis County Integral Care				133542405
Related Category 3 Outcome Measure(s):	133542405.3.9	IT-6.1.5	Percent improvement in satisfaction over baseline of patient satisfaction scores on health/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-1: Develop screening criteria and process for selecting eligible program participants Metric 1 P-1.1: Screening criteria and process are documented Goal: Criteria and process are developed Data Source: Project Documentation **Milestone 1** Estimated Incentive Payment **$750,041** **Milestone 2 P-2** Identify population for intervention Metric 2 P-2.1: Number of individuals meeting criteria Goal: Identification methods are operational Data Source: Project records Milestone 2 Estimated Incentive Payment **$750,041** **Milestone 3 P-3:** Hire staff Metric 1 P-3.1: Number of staff hired Goal: Hire 10 program staff Data Source: Project Personnel Records **Milestone 3** Estimated Incentive	**Milestone 6 P-9** Develop assessment procedures/materials for identification/tracking/monitoring of self-defined wellness goals Metric 1 P-9.1: Forms and databases Goal: Develop needed forms/databases Data Source: Project Documentation **Milestone 6** Estimated Incentive Payment: **$411,820** **Milestone 7 P-X** Enroll individuals in CDM self-management programs Metric 1:P-X.1 75 Number of individuals enrolled Goal: Enroll 75 SMI consumers Data Source: EMR and other project records **Milestone 7** Estimated Incentive Payment: **$411,820**		**Milestone 8** P-X Increase by 125 number of target population served Metric 1 P-X.1 Number of individuals enrolled Goal: 125 additional enrollees Data Source: EMR and project database documentation Milestone **8** Estimated Incentive Payment: **$881,102** **Milestone 9 P-10** Evaluate and continuously improve CDM self-management programs Metric 1 P-10.1 Plan documentation demonstrates use of PDSA QI process Data Source: Project reports use charts and dashboards Milestone **9** Estimated Incentive Payment: **$881,102**	**Milestone 10 P-X** Increase by 150 number of target population served Metric 1 P-X.1 Number of individuals enrolled Goal: 150 additional enrollees Data Source: EMR and project database documentation Milestone **10** Estimated Incentive Payment: **$851,306** **Milestone 11 P-13** Participate in 2x yearly meetings with RHP providers to share and promote learning about project experience Metric 1 P-13.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP Data Source: Documented meeting participation, agendas, minutes, meeting notes Milestone **11** Estimated Incentive Payment: **$851,307**

133542405.2.5	2.14.1	2.14.1A-G	Implementation of Chronic Disease Prevention/ Management Program	
Austin Travis County Integral Care				133542405
Related Category 3 Outcome Measure(s):	133542405.3.9	IT-6.1.5	Percent improvement in satisfaction over baseline of patient satisfaction scores on health/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)**
Payment **$750,041** **Milestone 4 P-4:** Train staff in required knowledge skills and abilities Metric 1 P-4.1 Number of staff trained Goal: Train all hired staff Data Source: Project training records/ curricula **Milestone 4** Estimated Incentive Payment **$750,041** **Milestone 5 P-X** Enroll individuals in CDM self-management programs Metric 1:P-X.1 50 Number of individuals enrolled Goal: Enroll 50 SMI consumers Data Source: EMR and other project records **Milestone 5** Estimated Incentive Payment **$750,041**				
Year 2 Estimated Milestone Bundle Amount*:* **$1,500,082**	Year 3 Estimated Milestone Bundle Amount: **$1,647278**		Year 4 Estimated Milestone Bundle Amount: **$1,762,204**	Year 5 Estimated Milestone Bundle Amount: **$1,702,613**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $6,612,177				

Austin Travis County Integral Care
Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services
Project Identifier: 133542405.2.6 Pass 2

Provider: Since 1966, Austin Travis County Integral Care (ATCIC) has been committed to providing services for children, families and adults with behavioral health disorders. In fiscal year 2011, more than 23,000 individuals and families received services from ATCIC, of who 10,000 were adults with serious mental illness (SMI). ATCIC is the Local Mental Health Authority for Travis County and Joint Commission accredited.

Intervention(s): The project will implement a multi-component, evidence-based peer support training curriculum addressing the traditional roles of peer supports in mental health and expand skill sets to help peers and those with whom they work to adopt whole health life styles (e.g., tobacco-free, proper nutrition, routine exercise).

Need for the project: While ATCIC already employs peer support specialists, they have not been formally trained to serve the whole health needs of consumers. Given the prevalence of chronic disease conditions with ATCIC's consumers and their struggle with SMI, adding an integrated chronic disease management to a peer support training program would benefit a majority of the 7,500 adults with SMI currently receiving services.

Target population: The target population are ATCIC consumers who are at-risk of or currently have chronic health conditions. The vast majority of ATCIC patients are Medicaid and/or indigent. Currently, approximately 38 percent of individuals served by ATCIC have Medicaid and/or Medicare. All other individuals served are funded through state general revenue funds received from the Department of State Health Services.

Category 1 or 2 expected patient benefits: Providing peers support services of this scope will be a new service for ATCIC and RHP-7 and will require establishing a baseline. The baseline for this project is set with assessments conducted in DY2 and determined by DY3.

Category 3 outcomes: OD-6, IT-6.1 Our goal is to improve over baseline patient satisfaction on their health/functional status for those involved in Peer Support programs.

Title of Project: **Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services**

Category / Project Area / Project Option: **Category 2.18.1**

RHP Project Identification Number: **133542405.2.6 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Project Description

Overall Project Description - Austin Travis County Integral Care (ATCIC) proposes an expansion of its peer support services to incorporate a "whole health" approach in serving consumers. More specifically, the project will recruit, train, and support consumers of mental health services to provide an enhanced model of peer support services that incorporates whole health services. Whole health services focus on prevention and self-management of chronic diseases such as diabetes and co-occurring psychiatric disorders (COPD).

Since 1966, Austin Travis County Integral Care (ATCIC) has been committed to serve children, families and adults with behavioral health disorders. ATCIC is the Local Mental Health Authority (LMHA) for Travis County and carries out its mission with funding from a variety of grants and local, state and federal sources. ATCIC is Joint Commission accredited and provides the following services: behavioral health to adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED), intellectual and developmental disabilities, and psychiatric crisis services. In fiscal year 2011, ATCIC served more than 22,000 individuals and families, often in dire need of treatment. Currently, approximately 38 percent of individuals served through ATCIC services have Medicaid and/or Medicare. All other individuals served are funded through state general revenue funds received from the Department of State Health Services.

Currently, ATCIC serves approximately 6,000 adults with SMI every year in various outpatient programs at more than 15 locations in Travis County. Individuals with psychiatric illness are frequently marginalized and experience comparatively greater physical, sexual and emotional trauma compared to the general population.[1] When asked, individuals served in our systems of care frequently describe feeling isolated, excluded from decisions related to their own care, and confused by the complexity of the healthcare system. They further experience a profound disparity in life expectancy. The latest studies indicate that they die 25 years sooner than the rest of the population.[2]

Peer support programs have been shown to empower individuals struggling with psychiatric illnesses by linking them with people who have also struggled with the same illnesses.[3] Peer support is a non-medical model of care based on a number of psychosocial processes such as: social support; experiential knowledge derived the peer support's own life experience; social learning theory as peers; having experienced and survived relevant events serve as credible role models; and social comparison theory (e.g. individuals are more comfortable interacting with others who share common characteristics).[4] Peer support further incorporates the helper-therapy principle designed to increase peers' sense of interpersonal competence, perceived equality with others and enhanced insight into their own condition.[5]

More recently, evidence supports the effectiveness of adding a whole health approach to peer support services in improving health outcomes for persons with severe mental illness.[6] Given the prevalence of chronic disease conditions of ATCIC's consumers and their struggle with SMI, adding an integrated chronic disease management to a peer support training program would benefit many of the 7,500 adults with SMI currently receiving services.

While ATCIC already employs peer support specialists, they have not been trained or used in serving the whole health needs of consumers. In this DSRIP project, ATCIC will expand their existing peer training resources and greatly enhance the capacity of their peer supports. ATCIC will specifically recruit and train community peer support specialists using current, evidence-based current curricula and add Health Promotion and Wellness modules such as tobacco cessation, healthy eating, active living and elements of Mental Health First Aid. The goal is to increase the number of peer support specialists and to train them in the more comprehensive whole health approach, thus enhancing the life quality of individuals who are trained and work as peer supporters, and the consumers with whom they work.

Project Goals - To implement a multi-component, evidence-based peer support training curriculum addressing the traditional roles of peer supports in mental health and expand skill sets to help peers and those with whom they work to adopt whole health life styles (e.g., tobacco-free, proper nutrition, routine exercise).

The four year target goals include conducting an organizational readiness assessment to determine what changes must occur to successfully integrate peers into the traditional workforce in Demonstration Year (DY) 2. In DY3, ATCIC will identify and train peer specialists to conduct whole health classes and in DY4 and DY5, demonstrate the improved health outcomes of the people who participate in whole health peer support and experience improvement in standardized health measures.

It is anticipated that each peer provider specialist will provide between 400-600 duplicated encounters for adults receiving outpatient behavioral health services at ATCIC. The total number of duplicated encounters provided by 10 peer specialists will be between 4,000-6,000 encounters per year.

Challenges or Issues Faced by the Performing Provider - ATCIC has long realized that chronic disease management is a critical component of treatment for people with SMI. Due to limited resources, the primary focus in Travis County and across Texas has been on the integrated physical and behavioral health model, which does not account for the complexity of chronic disease management for people with SMI. Although evidence demonstrates the benefits of peer supports for the overall health, there are limited peers trained to deliver such services. A significant challenge to training and expanding peer support specialists will be identifying and recruiting consumers.

How the Project Addresses those Challenges – ATCIC will use its experience in successfully managing peer support programs to identify, engage and mentor peer support specialists in whole health services. Once launched, ATCIC will provide long-term and intensive follow-up services as part of a multi-component model to ensure success. Research indicates the longer and more intensive the follow-up, the more successful the interventions are in achieving program goals: tobacco cessation, improved diet, continued exercise and reduction of elevated blood sugar and cholesterol levels.[3]

How the Project is Related to RHP Goals – The six counties that comprise RHP Region 7 in Texas have identified seven RHP goals, of which, the following five relate to this project:

1. Prepare and develop infrastructure for health improvements;
2. Improve patient care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems;
3. Bolster individual and population health by improving chronic disease management; and,
4. Support prevention education and healthy lifestyles to improve population health.

ATCIC can maximize the health and wellness of individuals with SMI with help from peer support specialists. This addresses the whole person by concurrently treating SMI and chronic health care conditions as an integrated healthcare approach.

Starting Point/Baseline

Baseline Data – ATCIC anticipates that each peer provider specialist will provide between 400-600 duplicated encounters for adults receiving outpatient behavioral health services at ATCIC. The total number of duplicated encounters provided by 10 peer specialists will be between 4,000-6,000 encounters per year. Providing peers support services of this scope will be a new service for ATCIC and RHP-7 and will require establishing a baseline for the number of unduplicated assessments provided by peer specialists. The baseline for this project is set with assessments conducted in DY2 and will be determined by DY3.

Time Period for Baseline: Baseline data on number of assessments conducted will be collected during DY1.

Rationale

Reason for Selection of Project Options and Components- This project will incorporate the core components of designing, implementing and evaluating whole health peer support for individuals with mental health and/or substance use disorders. More specifically, the project will: (a) train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system, (b)conduct readiness assessments of organization that will integrate peer specialists in their network, (c)identify peer specialists interested in this type of work, (d)train identified peer specialists in whole health interventions, (e)implement health risk assessments to identify existing and potential health risks for behavioral health consumers, (f)identify patients with serious mental illness who have health risk factors, (g) implement whole health peer support (h)connect patients to primary care and preventative services, and (i) track patient outcomes.

Reason for Selection of Milestones & Metrics - While the intent is to increase the number and availability of whole health peer support specialists, Process Milestones/metrics P1 and P2 were selected because they best fit the required steps in effectively expanding a peer support program to incorporate a whole health approach with the population of persons with SMI that ATCIC serves. The process milestones/metric involves conducting an organizational assessment and identifying and training whole health peer support specialists. Milestones 3 and 4 were chosen to evaluate and demonstrate the improvement in health outcomes for those that participate in whole health peer support programs.

Unique Community Need Identification Number – CN.9, CN.10, CN.11, and CN.16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative - While ATCIC already employs peer support specialists, they have not been trained or used in serving the whole health needs of consumers. In this DSRIP project, ATCIC will expand their existing peer training resources and greatly enhance the capacity of their peer supports through outreach and training. ATCIC will specifically recruit and train community peer support specialists using current, evidence-based current curricula and add health promotion and wellness modules such as tobacco cessation, healthy eating, active living and elements of MHFA.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) -None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected: OD-6 Patient satisfaction; IT-6.1 Percent Improvement over baseline of patient satisfaction scores

Reasons/Rationale for Selecting the Outcome Measure(s) - Literature consistently shows satisfaction increase for people in care systems who have strong commitments to peer supports.[7]

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects - Enhanced peer support efforts will improve overall health outcomes with a focus on not only SMI, but chronic disease conditions as well. This will reduce use of emergency services for non-psychiatric illnesses.

List of Related Category 1 & 2 Projects: 133542405.2.1, 133542405.2.2, 01335424-05.2.14.1

List of Related Category 4 Projects: TBD

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

133340307.2.9: Adult Whole Health Peer Support
133340307.2.10: Adolescent Whole Health Peer Support
133340307.2.11: Family Partner
201320302.2.2: Expansion of Community Diabetes Project

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects – Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information. Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives that will bring together all levels of stakeholders who are involved in DSRIP projects. This multi-pronged approach should allow for continuous improvement of regional projects and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project – The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

References

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133542405.2.6	2.18.1	2.18.1	Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services
Austin Travis County Integral Care			133542405
Related Category 3 Outcome Measure(s):	133542405.3.10	OD-6, IT-6.1	Patient Satisfaction

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2 Conduct an organizational readiness assessment Metric 1: P-2.1 – Completion of organizational readiness assessment Baseline/Goal: No plan for implementing this project exists; goal is to produce plan for project throughout agency. Data Source: Organizational Readiness Document & Implementation Plan Milestone 1 Estimated Incentive Payment: $270,057	**Milestone 2**: P-3 identify and train peer specialists to conduct whole health classes Metric 1: P-3.1 – Number of peers trained in whole health planning Goal: Identify and Train 10 peer support specialists in Whole Health Approach Data Source: training records Milestone 2 Estimated Incentive Payment: $296,557	**Milestone 3**: I-18 - Health Outcomes Metric 1: I-18.1 - Improvements in standardized health measures for consumers who participate in whole health support Goal: 5% of people who participate in whole health peer support experience improvement in standardized health measures over DY-2 baseline Data Source: project data, medical record data, participants surveys Milestone 3 Estimated Incentive Payment: $317,247	**Milestone 4**: I-181 - Health Outcomes Metric 1: I-18.1 Improvements in standardized health measures for consumers who participate in whole health support Goal: 10% of people who participate in whole health peer support experience improvement in standardized health measures over DY-2 baseline Data Source: project data, medical record data, participants surveys Milestone 6 Estimated Incentive Payment: $306,519
Year 2 Estimated Milestone Bundle Amount:$270,057	Year 3 Estimated Milestone Bundle Amount: $296,557	Year 4 Estimated Milestone Bundle Amount: $317,247	Year 5 Estimated Milestone Bundle Amount: $306,519
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,190,380			

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Category 2 DSRIP Projects

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Transitional Housing Guided by Peer Support
126844305.2.1 Pass 1

Provider: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7. We serve a variety of persons through various contracts. Among those is a contract with the state to serve adults who are primarily diagnosed with Serious Mental Illnesses. BTCS is the only public provider of behavioral health services in the four Counties providing care in multiple locations throughout these mostly rural counties representing a population of 153,403.

Intervention(s): We plan to establish transitional residential facilities in these counties to include apartments that can be used while transitional services are provided then the apartment will be leased by the consumer upon successful completion of the program; and a leased facility large enough to have on-site staff and provide services to several consumers at once who then find housing in their communities and move out making room for new participants. No capital expense will be needed to secure these resources. The final phases of both of these methods will include transition assistance to community living.

Need for the project: There is little affordable housing in these Counties. People discharged and returning from hospital stay or from crisis events who are without family support become homeless for lack of resources. This allows a period of transition to achieve symptom stability, to get jobs and to regain routine functioning. This addresses RHP 7 Community Needs Assessment needs: CN.3 - Inadequate access to behavioral health care; and CN.6 - Inadequate services throughout the continuum of care for individuals with behavioral health issues, specifically supported housing, and residential treatment.

Target population: The target population is adults with serious mental illnesses who do not have a stable living situation and are without family or community support resources. We expect to serve about 20 people in DY 4 and 24 people in DY5 in this specialized housing program. BTCS served 5,706 persons in the four Counties in FY 2012; 5,337persons with behavioral health disorders. In FY 2012, an average of 43% of the adults were eligible for Medicaid; 73% of BTCS clients are below the federal poverty level; 55% are uninsured. We estimate that approximately 70% of those benefitting from this project will be poor, uninsured or underinsured.

Category 1 or 2 expected patient benefits: Providing training and supports through Peer Specialists in this transitional housing setting will improve the functioning of the individuals in the program thereby supporting the Outcome Measure below. We will seek to serve 20 people in DY 4 and 24 in DY 5. Stable living gives provides an opportunity to improve life skills and functioning.

Category 3 outcomes: IT-3.8 The baseline is TBD in DY 3. Our goal is to reduce the behavioral health /substance abuse 30 day readmission rate to inpatient facilities by 10% in DY 4 and 20% in DY 5. This will be achieved by providing housing, supports and training to improve functioning.

Title of Project: **Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above: Transitional Housing Guided by Peer Support**

Category / Project Area / Project Option: **2.13.2**

RHP Project Identification Number**: 126844305.2.1 Pass 1**

Performing Provider Name**: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services**

Performing Provider TPI**: 126844305**

Project Description

Overall Project Description

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7. We serve a variety of persons through various contracts. Among those is a contract with the state to serve adults who are primarily diagnosed with Serious Mental Illnesses (SMI). SMI is defined as"…, adults with a serious mental illness are persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM-III-R and … that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.…" (Federal Definition for SMI http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc.)

This group of patients generally suffers from the most profound deficits in functioning and are often unemployed, homeless or living in sub-standard housing and without natural family or community supports. BTCS proposes to implement a transitional housing project that is built on recovery principles and guided by peer support. (National Consensus Statement on MH Recovery, http://www.samhsa.gov/SAMHSA_News/VolumeXIV_2/article4.htm).

This project will be consistent with the description in the *RHP Planning Protocol, Category 2,* page 301, Project Option 2.13.2 Notes, "Residential Assistance (…Supervised Living …and Residential Support Services.)" We plan to use two facility approaches to implement this residential assistance: 1) locate apartments that can be used while transitional services are provided then the apartment will be leased by the consumer upon successful completion of the program; 2) identify and lease a house large enough to have on-site staff and provide services to several consumers at once who then find housing in their communities and move out making room for new participants. The final phases of both of these methods will include transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens so that individuals can smoothly move into community. The Transition Services will be provided by peers, consistent with *RHP Planning Protocol, Category 2*, page 302, Project Option 2.13.2 Notes, "Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals." The project will be consistent with SAMHSA recognized recovery principles as stated in the Consensus Statement referenced above, and staffed by peer support specialists with professional support provided through local BTCS clinics. BTCS currently has vehicles and uses Peers to transport to medical appointments and community activities. Peers also provide recovery support services in outpatient settings. BTCS participates in Mental Health Task Forces in all four Counties we serve and those advocates and community leaders have identified a need for housing in their

communities and for supervised living assistance that can be used to help people make the transition from inpatient and crisis events to recovery. We have local support for and plan to identify suitable facilities in Bastrop, Texas for development of transitional housing facilities. The large leased house option can be used for people who come from and might relocate back to any of the four Counties. The target population is adults with SMI who are released from inpatient care or have experienced a recent crisis event such as ED visits, jail stay, etc., and are either without community support resources and housing or without acceptable housing. There are several evidence based practices based on recovery principles and each one adopts some process to guide participants through identifying and understanding their personal wellness resources then helping them develop an individualized plan to use these resources on a daily basis to manage their mental illness. The programs agree that this assistance is best provided by peers. ("Developing a Recovery and Wellness Based Lifestyle Guide," http://store.samhsa.gov/product/Developing-a-Recovery-and-Wellness-Lifestyle-A-Self-Help-Guide/SMA-3718 ; and "Consumer Operated Services – EBP," http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD .)

Project Goals

The goals for the Performing Provider, BTCS, over the next five years will be: develop at least two facility sites; recruit and certify Peers to provide transitional services; and serve 20 people in DY4 and 24 people in DY 5. The goals for the program participants are to learn skills to self-manage their wellness and skills to support the activities of daily living and live independently in a community setting. When these goals are achieved we expect the outcomes to be: that individuals to regain functioning so that they can avoid readmission to the hospital; and individuals will have fewer emergency department visits, fewer state hospitalizations and a lower rate of arrests and fewer days incarcerated.

Challenges or Issues Faced by the Performing Provider

I. Two major challenges will be: finding adequate housing resources in the community to operate the program; and finding adequate resources for persons successfully completing the program. Another key challenge will be recruiting, training and certifying Peer Support Specialists.

How the Project Addresses those Challenges

II. We are fortunate to have a long standing presence in the community and the support of community leaders who can assist in identifying suitable locations for independent housing. Over the next few months staff will assess houses and apartment complexes that BTCS could access. We will also work with them to find other locations in the future. We have already initiated an active program of recruitment and training of Peer Support Specialists. We employ recognized leaders in peer advocacy and support. During DY 2 we will be actively recruiting individuals with SMI for training and certification related to this specific project.

How the Project is Related to RHP Goals

This project advances RHP Goal 2. "Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting." The opportunity to live outside of repeated institutional care is critical to right care and right setting. The project also advances RHP Goal 6. "Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery." This recovery based program directly addresses this Goal.

Starting Point/Baseline

Baseline Data

Currently no Transitional Housing program exists in the four Counties; therefore, the baseline is 0 in DY 2.

Time Period for Baseline

The time period for the baseline is DY 2.

Rationale

Reason for Selection of Project Options and Components

We selected Project Option2.13.2 – *"Other" project option: Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above."* We selected the "Other" option even though it is not associated with a set of Core Components because the project incorporates at least six of the community-based interventions listed under this Option including:

- Residential Assistance (Supervised Living, Residential Support Services);
- Psychosocial Rehabilitation;
- Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
- Transportation to appointments and community-based activities;
- Prescription medications;
- Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals.

The fundamental building blocks of this project are found in the first and last bullets above.

Even though there are no Core Components associated with this option, we will take a careful development path for this project. We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gaps that must be filled to secure housing and to gain the skills for a smooth transition. With these stakeholders, we will identify tools to provide data to get an inventory of community resources currently utilized and those needed by the people we expect to serve. We will use the current staff to assess current needs of those who are now hospitalized and soon to be discharged and those experiencing crisis events needing transition to community housing. Using the information from stakeholders, from capacity and utilization tools, from further literature reviews and from assessment of those potential referrals, we will assess the intervention we are planning to provide. As we implement the Transitional Housing Project we will implement a rapid cycle quality improvement component through the Quality Management Department at BTCS. We plan to continuously improve the program over the next 5 years as we adjust the interventions, peer supports and make changes based on lessons learned. Continuous Quality Improvement: The Center is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as "lessons learned" and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

Reason for Selection of Milestones & Metrics

We selected assessment, design and continuous quality improvement Process Milestones, p-2, P-3 and P-4; for DY2 and DY3 because we are starting a new program that has not been implemented in this Region and we must ensure that the right population is targeted with the right interventions and that the program is continuously adjusted as we learn how to help people succeed through the use of peers, supports and transitional services. This set of Milestones and Metrics are similar to core components found associated with the companion Project Option: "Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population, (*RHP Planning Protocol, Category 2*, page 301, Project Option 2.13.1.) We will measure

progress toward community assessment and development of infrastructure such as policies, training materials, contracts and support.

We selected the I-X Number of patient interventions. It is critical to success for housing to be secured. This is a group of people who have multiple hospitalizations and great difficulty maintaining community tenure. Stable living provides an opportunity to improve life skills and will improve functioning so that we can achieve the Outcome of reducing Potentially Preventable Readmissions to psychiatric hospitals.

These Milestones and Metrics are specifically related to the targeted population of individuals who have recent crisis events that sometimes result in hospitalizations with the aim of providing them the best opportunity to make a recovery oriented transition to the community and thereby prevent further crises and hospitalizations.

Unique Community Need Identification Number

CN.6 – crisis stabilization services

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

BTCS currently employs Peer Support Specialists to enhance services in all outpatient programs. This system reform initiative will be enhanced by utilizing additional Peers in the vital role of promoting wellness and self-management. Also as stated above, this will create a community hub for Recovery activities.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

BTCS provides some outpatient mental health services with funding from the Community Mental Health services block grant provided through the Department of State Health Services from US Department of Health and Human Services. These transitional housing services do not utilize Federal Funds than those from the DSRIP pool. This project does not pay for or duplicate services currently provided through CMS Block Grant, however individuals using the housing services are eligible and will likely access outpatient care **in addition to the transitional.** Their access to the outpatient services is critical **to supplement the activities and services of the Transitional Housing project**. The outpatient services provided over and above the services of the Transitional Housing project include medication management, symptom relief and to receive psychosocial rehabilitation. Unless individuals can remain in remission from their symptoms, they will not be able to succeed in the Transitional Housing project and therefore the current services enhance the project.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Reasons/Rationale for Selecting the Outcome Measure(s)

We selected this measure because the goals stated above are that we will establish a supervised residential program with peer guided supports targeted specifically at individuals who are being discharged from a psychiatric hospital or other psychiatric stabilization option. If we achieve our goals the participants will experience improved functioning and learn to self-manage their wellness therefore reducing the frequency of readmission to psychiatric inpatient and/or stabilization facilities. The Transitional Housing Guided by Peer Support project assists people in their recovery, provides resources to support wellness and self-management, and integrates people into housing of their own in the community. These steps will clearly reduce disruptive readmissions to hospital and use of emergency services.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The project will be intertwined with new projects proposed by BTCS and existing programs. It is anticipated that some referrals will come from individuals who have been diverted from county jails or emergency services into our Crisis Respite project that is being developed in RHP 8. That program provides stabilization in lieu of hospitalization and some of those admitted will be from the RHP 7 Counties and in need of transitional housing. We also anticipate that some high functioning individuals with Intellectual and Developmental Disabilities who are provided wrap around services through our IDD Assertive Community Treatment project, in Pass 2 may be eligible for and need these transitional housing services. These services will support successful community living.

List of Related Category 1 & 2 Projects *(in the order referred to above): 1264883-05.1.2 in RHP7; 1268443-05.2.*
List of Related Category 4 Projects *(RHP Project ID Number)*
N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

201320302.2.1: Provide ACT Model for Participants of HF PSH
137265806.1.1: Psychiatric Emergency Department

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

Because of the reliance on Wellness and Recovery principles supported by peer specialists, we expect to participate in learning collaborative with ATCIC. Additionally, we have participated in learning collaboratives through the Texas Council of Community Centers related to Recovery and will continue to look for these opportunities. This exchange of ideas is important and helps us adjust and refine our programs and approaches to care.

III.

Project Valuation

IV.

Approach for Valuing Project

This project seeks to provide transitional housing services for 20 people in DY4 for and 24 people in DY5. Although this is a small number of people, but this is a group of people who have multiple hospitalizations and great difficulty maintaining community tenure. Stable living gives provides an opportunity to improve life skills and functioning. This represents a substantial savings when compared to bed day costs for inpatient psychiatric facilities and substantial patient benefit in that it supports a healthy life in the community. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description

of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this project, in which people work toward their optimum level of recovery and independence, the cost utility of that community tenure is one gauge of value along with system health care costs and specific health system benefits. This method allows us to compare these disparate elements.

126844305.2.1	***2.13.2***	***N/A***	***Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above: Transitional Housing Guided by Peer Support***	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services				*126844305*
Related Category 3 Outcome Measure(s):	*126844305.3.3*	*3 IT 3.8*	*Behavioral Health / Substance Abuse 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-2]: Design community-based specialized interventions for SMI behavioral health target populations frequently hospitalized and/or homeless. Interventions may include (but are not limited to) residential assistance (foster/companion care, supervised living, residential support services) Metric 1 [P-2.1]: Project plans which are based on evidence / experience and which address the project goals. Goal: Produce a comprehensive report detailing all the elements in the Milestone and Metric. Data source: project documentation Milestone 1 estimated incentive payment (maximum amount): $326,916 **Milestone 2** [P-3]: Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant	**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 1 [P-3.1]: Number of targeted individuals enrolled / served in the project. Goal: Enroll 18 individuals in DY3 Data Source: Project documentation and EHR Milestone 3 Estimated Incentive Payment: $315,350 **Milestone 4** [P-4]: Evaluate and continuously improve interventions) Metric 1 [P-4.1]: Project planning		Milestone 5 [I-X]: Number of patient interventions. Metric 1 [I-X.1]: Number of patient in target population served at this new transitional housing site. Baseline/Goal: Baseline - 0 since no such site is currently located in RHP; Goal - Serve 20 people in DY 4. Data Source: EHR Milestone 5 Estimated Incentive Payment: $700,378	Milestone 6 [I-X]: Number of patient interventions. Metric 1 [I-X.1]: Number of patient in target population served at this new transitional housing site. Baseline/Goal: Baseline - 0 since no such site is currently located in RHP; Goal - Serve 24 people in DY5. Data Source: EHR Milestone 6 Estimated Incentive Payment: $629,105

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 1 [P-3.1]: Number of targeted individuals enrolled / served in the project. Goal: Admit 1 person. Data Source: EHR Milestone 2 Estimated Incentive Payment: $326,916	and implementation documentation demonstrates plan, do, study act quality improvement cycles. Goal: Produce comprehensive planning and implementation report that demonstrates PDSA cycle. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 4 Estimated Incentive Payment: $315,351		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $653,832	Year 3 Estimated Milestone Bundle Amount: $630,701	Year 4 Estimated Milestone Bundle Amount: $700,378	Year 5 Estimated Milestone Bundle Amount: $629,105
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,614,016			

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD)
126844305.2.2 Pass 2

Provider: Bluebonnet Trails Community Services (BTCS) is the state designated Local Authority (LA) in Bastrop, Caldwell, Fayette and Lee Counties in Region 7 with responsibility for assessing the service and support needs of individuals with Intellectual and Developmental Disabilities (IDD,) coordinating service planning and assembling a network of providers to meet those needs. As the LA we are also required to serve as the Safety Net for individuals with IDD throughout these four mostly rural Counties with a population of 153,403.

Intervention(s): BTCS proposes to provide Assertive Community Treatment (ACT) team services for individuals with IDD at points of crisis and during life transitions. Through this project we will divert people with IDD from higher cost, institutional placement and support them in community living with a team of behavior specialists and providers. The project will also provide specialized consultation to attending physicians as well as education and training to emergency services personnel that assess and respond to IDD crises. Consultation and education will help these components of the health care and emergency response system to provide proper care.

Need for the project: Individuals with IDD display challenging and/or harmful behaviors at times of stress or change and these behavior issues are frequently confused with behavioral health issues or crises and therefore addressed in ways that do not help or may escalate the problem. This addresses RHP 7 Community Needs Assessment needs: CN.4 – Inadequate access to behavioral health care; CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues such as: crisis stabilization services; and CN.8 – High rates of non-emergent emergency department usage and potentially preventable inpatient admissions.

Target population: The target population is individuals with IDD who are taken to EDs in our region or in jeopardy of losing community living placements due to behaviors that are challenging or dangerous. We anticipate serving about 50 persons annually once the program is matured. BTCS served 527 persons with IDD in these counties in FY 2012 and 50% were Medicaid eligible. We expect at least 50% of those benefitting from these services to be Medicaid beneficiaries.
Category 1 or 2 expected patient benefits: We expect to serve 30 people in DY 4 and 50 people in DY 5. The behavior plan and team services will help individuals to improve regain their functioning level and return to community living. Services will continue until the individual is stable and comfortable in their setting.
Category 3 outcomes: IT-9.2 Our goal is to reduce ED utilization by persons with IDD by a percentage TBD after baseline is established in DY 3. Providing services from a team at the point of crisis and to stabilizing the situation directly supports this outcome.

Title of Project: **Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD); for Bastrop, Caldwell, Fayette and Lee Counties**

Category / Project Area / Project Option**: 2.13.1**

RHP Project Identification Number: **126844305.2.2 Pass 2**

Performing Provider Name: **Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services**

Performing Provider TPI**: 126844305**

Project Description

Overall Project Description

Bluebonnet Trails Community Services (BTCS) proposes to provide Assertive Community Treatment (ACT) team services for individuals with Intellectual and Developmental Disabilities (IDD) at points of crisis and during life transitions such as when individuals move from natural supports, discharge from State Supported Living Centers (SSLC formerly 'State Schools') or Intermediate Care Facilities/Intellectual Disabilities-Related Condition (ICF/ID-RC.) Through this project we will divert people with IDD from higher cost, institutional placement and support them in community living. The project will also provide specialized consultation to attending physicians as well as education and training to emergency services personnel that assess and respond to IDD crises. Consultation and education will help these components of the health care and emergency response system to provide proper care.

Individuals with IDD have a disability rather than an illness and need services and supports to compensate for those disabilities. BTCS is the state designated Local Authority (LA) in Bastrop, Caldwell, Fayette and Lee Counties in Region 7 with responsibility for assessing the service and support needs of individuals with IDD, coordinating service planning and assembling a network of providers to meet those needs. "Providers" refers to individuals and entities providing services and supports to persons with IDD in residential and non-residential settings. As the LA we are also required to serve as the Safety Net for individuals with IDD. Our experience is that persons displaying challenging or harmful behaviors in foster care, group homes and ICF/ID-RC settings are frequently brought to Emergency Departments (EDs) for treatment and stabilization of what is frequently misidentified by the provider as a mental illness. BTCS is also the state designated Local Mental Health Authority (LMHA) in the same counties with similar responsibilities for assessment, treatment planning and ensuring treatment services are available for individuals with mental illnesses. Individuals with IDD display challenging and/or harmful behaviors but these behavior issues are to be distinguished from behavioral health issues or crises. "Behavioral health" refers to the health care activities related to diagnosis and treatment of mental illnesses and substance use disorders. Behavior issues are often preceded by times of stress such as changes in care giver, changes in living situations, other life changes that might be customary but still result in a need for crisis response. Sometimes the behavior issues are a result of co-occurring mental illnesses. But even when the person with IDD exhibits symptoms of a mental illness rather than solely behavior issues, there is still a need to provide specialized behavioral health interventions. Research indicates that as many as 33% of individuals with IDD have a co-existing mental illness (*Social Work Today*, Vol. 10 No. 5; Quintero & Flick, 2010.) There are two issues this project will address: misdiagnosis and improper response to behavior issues as though they were mental illnesses; and improper treatment and response for individuals with IDD who are also mentally ill. Both result in persons with IDD being removed from community

placements and returned to institutions, long stays in hospitals, long stays in ED's and inappropriate arrest and detention of these individuals.

BTCS has developed specialized interventions for persons diagnosed with Autism Spectrum Disorders and currently provides ACT tam services for persons who need intensive mental health services. ACT teams are well documented best practice as intervention for persons with Serious Mental Illnesses (SMI) who have a difficult time maintaining community tenure. The intervention is included in the SAMHSA, Evidence Based Practices registry and a Toolkit for implementation of ACT is available through them. Behavioral health ACT teams consist of psychiatrist, nurse, caseworkers, housing specialists, employment specialists. Every team member is familiar with each patient helping him/her adapt and live successfully in the community rather than in an institution. This group of services is described as 'wrap around' services because the entire bundle of services is available at any time it is needed and delivered by any member of the team, thus providing a community safety net wrapped around the individual. We propose apply this modality for persons with IDD. The ACT team for individuals with IDD will be led by a Licensed Masters Level professional and will include a psychologist who is a behavior expert and a psychiatric consultant, nursing, service coordinator and community skills trainers. We will centrally locate the team to respond to service requests from any of the four Counties. The team will respond on site to wherever the individual with IDD is experiencing challenging behaviors to provide assessment and intervention to stabilize the situation. The ACT team will develop and implement a behavior plan to help the individual return to or remain in his/her current living situation and to successfully maintain that setting. Wrap around services will continue until the person is comfortable and stable. Team intervention is envisioned to be short term and intensive with the goal of helping persons retain community placement. In addition to direct client intervention, ACT team members will educate law enforcement, ED staff and physicians as well as IDD group home providers to create an understanding of the differences in diagnosis and response and to promote access to ACT team consultation and resources. BTCS participates in the Provider Workgroup Collaboration with providers in the region and in conjunction with Austin Travis County Integral Care (ATCIC.) BTCS also facilitates the regional Public Network Advisory Committee. Both of these stakeholder groups provided the impetus for the project by identifying the problem that repeated visits to EDs and admissions to mental health facilities or jails result in disruption of long-term residential placements.

Project Goals

One major goal for BTCS over the next five years will be to develop an ACT team model specializing in the assessment and stabilization of persons with IDD and respond to emergency situations involving persons with IDD throughout the four Counties. A second major goal is to provide education and training to law enforcement, emergency room personnel, health care providers, psychiatric hospital providers, and community residential and non-residential providers regarding how to recognize behavior issues in persons with IDD and how to access appropriate services through the ACT team. The goals for individuals with IDD are to reduce overuse of institutional care and to ameliorate crisis and preserve undisrupted community living. When persons with IDD receive the proper care and interventions, then admissions to institutional care and multiple visits to EDs are avoided.

Challenges or Issues Faced by the Performing Provider

The biggest challenge is that there is a pervasive misunderstanding in the health care community and in broader community concerning the differences in diagnosis and treatment between behavior issues for persons with IDD and behavioral health crises for persons with SMI. Another challenge is gaining acceptance by caregivers that the intervention will work and that it should be used instead of ED or law enforcement involvement.

How the Project Addresses those Challenges

This project will address the first challenge through education by engaging emergency medical professionals, IDD consumers and advocates throughout the RHP 7. We will provide didactic venues for this purpose but we also plan to fully engage these professionals to assist us in developing a protocol to implement ACT Teams for persons with IDD. We will then widely disseminate that protocol through a communication plan using resources of those community partners, further engaging them in this change process. This same education and communication will available for caregivers in order to address the second challenge. BTCS has well-developed IDD services and supports sites in each of the Counties and will use those facilities and connections to the community to offer support and education.

How the Project is Related to RHP Goals

This project advances RHP Goals 2 "Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting," and 6 "Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery." The aim if this project is to provide interventions at the point of crisis to resolve them and maintain community living.

Starting Point/Baseline

Baseline Data

Currently no ACT team services for persons with IDD, therefore, the baseline is 0 in DY 2.

Time Period for Baseline

The time period for the baseline is DY 2.

Rationale

Reason for Selection of Project Options and Components

There is no ACT team for persons with IDD currently in place in RHP 7 but there is evidence that a specialized intervention is needed for these individuals based on complaints from EDs, providers and law enforcement. ACT teams that include specialists in IDD who can assess needs and apply behavioral plans or other IDD specific interventions will reduce time in the ED, reduce misdiagnosis and placement in more restrictive settings. Because EDs are health care settings, all persons admitted have a diagnosis, even those displaying challenging behaviors rather than an illness. Therefore, currently available data does not accurately identify the number of persons with IDD who have been taken to EDs due to behavior problems. Our estimate of that number based on our experience is around 30% of all persons with IDD accessing EDs. We will only know the need accurately when we begin on site assessments and consultation with emergency medical staff.

BTCS participates in a pilot program through the Department of Aging and Disability Services (DADS) the aim of which to reduce institutional placement using the team approach. There are an increased numbers of individuals that have been referred to the LA for intake to IDD services that are in crisis due to the lack of appropriate resources to respond to the challenging or harmful behaviors. An increase of referrals from SSLC is expected for individuals with similar challenging behaviors transitioning to community living. BTCS now provides intervention on a case by case basis but we expect a growing need for a crisis intervention plan developed to insure supports are in place prior to the move for successful community living. At this time 5 referrals from the SSLC have been made. The ACT Team will enhance this current pilot project by establishing a specific response team that can be used for these individuals and others described above.

Project Components: This project to provide ACT team services for persons with IDD will address all of the required core project components:

a*) Assess size, characteristics and needs of target population.* Although the initial data cited above, gives a picture of the number of persons with IDD referred to EDs, all EDs are not included and the cause of referral does not differentiate for behavior issues. We will define the data needs and then gather information from electronic health records of EDs and case management reports from the LA to further refine the characteristics and needs.

b) Review literature / experience with populations similar to target population to determine community-based interventions that are. The staff for the LA has reviewed ACT literature to identify basic design of this project and the application of ACT to persons with IDD. As described above, we will engage stakeholders to develop specific protocols for the intervention. We will use that coalition to promote community understanding and response.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes. We will use BTCS quality management staff to facilitate the formation of learning collaboratives with the other community centers in RHP 7, both of which are proposing similar projects. We will meet and disseminate information among the group to ensure qualitative and quantitative metrics will be used to measure outcomes.

d) Design models which include an appropriate range of community-based services and residential supports. Using the information from stakeholders, community centers, evaluation metrics, functional assessments and reports; we will evaluate interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. As indicated below, preliminary research leads us to consider using Behavior Problems Inventory -01(BPI-01) or the Inventory of Client and Agency Planning (ICAP) as a functional assessment. Although familiar with both, we will perform additional research prior to implementation of the tools. Aggregated data from the assessment selected along with number of ED visits will be used to assess community impact and identify and respond to lessons learned.

Reason for Selection of Milestones & Metrics

For DYs 2 and 3 we selected Process Milestones, P-2, designing the intervention; P-3, enroll and serve persons in the targeted population with complex needs; and P-7, participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. We selected these Milestones because we are starting a new program, reflecting an innovative use of the well-known ACT team concept. This approach, as we have proposed it, has not been implemented before. We must ensure that the right population is targeted with the right interventions and that the program is continuously adjusted as we learn how to help people succeed. We selected this Milestone because it is important to us that persons with IDD remain in their long-term placements and community tenure and our experience is that tenure is jeopardized by a visit to an ED. Timely intervention by trained professionals will directly lead to appropriate ED utilization, the Outcome measure for this project.

Unique Community Need Identification Number

CN.4 – Inadequate access to behavioral health care; CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues such as: crisis stabilization services; and CN.8 – High rates of non-emergent emergency department usage and potentially preventable inpatient admissions.

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

BTCS participates in a pilot to reduce institutional care through DADS. This pilot is part of the Promoting Independence initiative in Texas which stems from U.S. Supreme Court's *Olmstead* decision (June 22, 1999) which supported the "integration mandate" of the Americans with Disabilities Act (ADA). Title II of the ADA requires

public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." This project supports and enhances that system reform initiative.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

BTCS provides some outpatient mental health services with funding from the Community Mental Health services block grant provided through the Department of State Health Services from US Department of Health and Human Services. No Federal Funds will be used in the organization and delivery of ACT services to this IDD population. The CMH Block Grant is currently used for adults with serious and persistent mental illnesses and will remain for that purpose.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD- 9 Right Care, Right Setting

IT-9.2 ED appropriate utilization

Reasons/Rationale for Selecting the Outcome Measure(s)

We selected this measure because the goals stated above are that we will establish Team that can respond and intervene during a crisis event. Quick intervention and continuing community education should achieve the outcome of appropriate ED utilization.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This project reinforces and might access resources other BTCS projects to include: Transitional Housing, Child Crisis Respite, Substance Abuse Outpatient and Services to the Justice Involved. Some individuals with IDD who are provided wrap around services through the ACT team may be eligible for and need these community services. We also anticipate that some of those needing services will be youth and need Child Crisis Respite.

List of Related Category 1 & 2 Projects (in the order listed above)

126844305.2.1; 126844305.2.1; 126844305.1.3; and 126844305.2.3

List of Related Category 4 Projects *N/A*

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

133542405.2.3: Crisis Residential Program,
133542405.2.4: Community Behavior Support (CBS) Team
201320302.2.1: Provide ACT Model for Participants of HF PSH
133542405.2.3: Community Behavior Support (CBS) Team
201320302.2.1: Provide ACT Model for Participants of HF PSH

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

We plan to develop a learning collaborative related to this specific project based on our long-term relationship with ATCIC and the Provider Workgroup. This collaborative will meet twice a year and form the basis of our CQI Process and raise the floor activities. We also plan to participate in other learning collaboratives related to our projects, that might be organized or initiated by the RHP 7 Anchor entity, Central Health.

Project Valuation

Approach for Valuing Project

We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve regain their functioning level and return to community living. This reduces inappropriate use of inpatient hospital and is of substantial benefit to the patient who can remain in a community living setting. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. This method allows us to compare these disparate elements.

126844305.2.2	***2.13.1***	***2.13.1 (a– e)***	***Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD); for Bastrop, Caldwell, Fayette and Lee Countie***
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 3 Outcome Measure(s): OD-9	*126844305.3.5*	*IT 9.2*	*ED appropriate utilization*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-2]: Design community-based specialized interventions for persons with IDD accessing EDs in crisis. Metric 1 [P-2.1]: Project plans which are based on evidence / experience and which address the project goals. Goal: Produce a comprehensive project plan that is used to implement the ACT team. Data source: project documentation, team notes concerning implementation. Milestone 1 estimated incentive payment (maximum amount): $119,014 **Milestone 2** [P-3]: Enroll and serve individuals with targeted complex needs. Metric 1 [P-3.1]: Number of targeted individuals enrolled /	**Milestone 3** [P-3]: Enroll and serve individuals with targeted complex needs Metric 1 [P-3.1]: Number of targeted individuals enrolled / served in the project. Goal: Enroll 6 persons in DY3 Data Source: Project documentation and EHR Milestone 3 Estimated Incentive Payment: $129,022 **Milestone 4** [CQI P-3]: Quality Improvement Milestone: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-4.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all scheduled	**Milestone 5** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline- 0 since no such service currently exists in the RHP; Goal - serve 30 people in DY4. **Data Source:** EHR, EMS and ED records. Milestone 5 Estimated Incentive Payment: $275,623	**Milestone 5** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline- 0 since no such service currently exists in the RHP; Goal - serve 30 people in DY4. **Data Source:** EHR, EMS and ED records. Milestone 6 Estimated Incentive Payment: $266,486

served in the project. Goal: Enroll 3 persons. Data Source: EHR Milestone 2 Estimated Incentive Payment: $119,015	meetings and develop improvement initiatives. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 1 [P-3.2]: Implement the "raise the floor" improvement initiatives established at the scheduled meetings. Goal: commit to the improvement and implement it. Data Source: Documentation of "raise the floor" improvement initiatives. Milestone 4 Estimated Incentive Payment: $129,023		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $238,029	Year 3 Estimated Milestone Bundle Amount: $258,045	Year 4 Estimated Milestone Bundle Amount: $275,623	Year 5 Estimated Milestone Bundle Amount: $266,486
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,038,183			

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services

Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Services for Justice-Involved Youth and Adults: Bastrop, Caldwell, Fayette and Lee Counties

126844305.2.3 Pass 2

Provider: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7 and for four other Counties in nearby RHPs. We are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. We are the only provider of public behavioral health services in these four mostly rural Counties with a population of 153,403.

Intervention(s): BTCS proposes to enhance its current services in Fayette County and expand services into the other three Counties for justice-involved youth and adults. We will provide screening, assessment and diversion recommendations to courts and law enforcement prior to long-term incarceration. To carry out this project, we will hire and train additional case management staff. The services will be delivered primarily in the field with staff offices available in our current offices in the four Counties.

Need for the project: BTCS maintains an active caseload of justice involved adults and youth of around 28 in these four Counties. In contrast, the state data system matches those booked into jail against persons served in the state mental health system. During the first 4 months of calendar year 2012, there were 165 exact matches for adults alone of incarcerated adults. This indicates that less than 10% of the need is being met for justice involved adults and we can assume that it is not better for youth. This project addresses RHP 7 Community Needs Assessment needs: CN.4 – Inadequate access to behavioral health care; and CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues

Target population: The target population is adults and youth who have a diagnosable behavioral health disorder and have been arrested or incarcerated. We seek to serve those whose charges are such that they are eligible for release or diversion from the system. No case management services will be provided until the person is released from jail. The case management services are not paid for by any other Federal Funds. Case management and recommendations are followed by referral to and engagement in active treatment services in the community. We expect to serve 150 individuals a year as the program matures. BTCS served over 7,769 with behavioral health disorders in FY 2012. An average of 43% of adults were eligible for Medicaid; 76% of youth were eligible for CHIP or Medicaid and 73% of BTCS clients are below the federal poverty level. Approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 150 people a year within five years.

Category 1 or 2 expected patient benefits: We expect to serve an additional 100 people in DY4 and 150 in DY5 achieving our Improvement Milestone I-X for Target Population Reached.

Category 3 outcomes: IT- 9.1Our goal is to decrease mental health admissions and readmissions to criminal justice settings such as jails or prisons by 10% in DY 4 and 25% in DY 5 against a baseline TBD in DY 3.

Title of Project: **Services for Justice-Involved Youth and Adults: Bastrop, Caldwell, Fayette and Lee Counties**

Category / Project Area / Project Option: **2.13.1**

RHP Project Identification Number: **126844305.2.3 Pass 2**

Performing Provider Name: **Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services**

Performing Provider TPI: **126844305**

Project Description

Overall Project Description

Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7 and for four other Counties in nearby RHPs. In that capacity we are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. That responsibility includes identifying gaps in service or barriers to access for persons residing in the area. We also provide direct treatment services under contracts with a variety of payers, including the Department of State Health Services (DSHS) and the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) to provide specialty behavioral health services to the "priority population." BTCS proposes to enhance its current services in Fayette County and expand services into the other three Counties for justice-involved youth and adults. Our plan is to expand eligibility criteria beyond the priority population for Fayette County and provide these expanded services in all four Counties. We will serve a broader range of mental illnesses including substance use disorders and serve those who are charged, adjudicated and proposed for release within the County justice systems. The goal of the program is to provide screening, assessment and diversion recommendations prior to long-term incarceration. To carry out this project, we will hire and train additional case management staff. The services will be delivered primarily in the field with staff offices available in our current offices in the four Counties. These staff will work with current TCOOMMI funded positions to enhance and expand treatment services provided to current patients and to a new broader range of eligible program participants, both youth and adults.

As stated, BTCS currently provides specialty services to the priority population defined by DSHS and TCOOMMI. This population includes children and adolescents with Serious Emotional Disturbance ('SED') and adults, who are primarily diagnosed with Serious Mental Illnesses (SMI), (Federal Definition for SED and SMI can be found at: http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc). Youth diagnosed with SED are generally having adjustment or functioning difficulties in more than one life domain and therefore experience crisis episodes that disrupt schools and families alike. Adults with SMI generally suffer from the most profound deficits in functioning and are often unemployed, homeless or living in sub-standard housing and without natural family or community supports. These patients need psychiatric and psychosocial rehabilitative services and are in serious jeopardy when placed in prison and juvenile probation facilities. However, there are a large number of individuals with behavioral health disorders that fall outside the priority population of DSHS who also need the same set of services and could benefit from treatment and potentially be diverted from incarceration. BTCS operates a service funded by TCOOMMI in Fayette County that serves this specialty population and provided care in FY 2012 to 23 individuals in that County along with 5 people from the other three counties. In contrast, the state

data system matches those booked into jail against persons served in the state mental health system. During the first 4 months of calendar year 2012, there were 165 exact matches for adults alone. This indicates that less than 10% of the need is being met for justice involved adults and we can assume that it is not better for youth.

There are two aspects to improving services for justice-involved youth and adults, first is screening, assessment, treatment planning and referral combined with linkage through the court and the probation and parole system. The project addresses this by increasing the case management staff that carry out all of those functions. The second is providing the treatment services required to meet the needs identified by the assessment and treatment planning. The treatment availability issue is addressed through several other DSRIP projects BTCS has proposed; youth counseling in Fayette and Lee Counties, primary care and behavioral health care integration in Caldwell County, transitional housing in Bastrop County and child crisis respite services throughout the Region. The project case management staff will provide a critical assessment, evaluation and when appropriate recommendations for community based services. This recommendation will give judges and other justice system officials' alternatives to incarceration. If the judge or probation officers agree the BTCS case manager will arrange transportation, temporary housing and necessary services and then link to ongoing services.

Project Goals

The expected outcome over five years is that fewer adults and youth with behavioral health diagnoses who commit minor crimes stemming from the deteriorated mental state will need to be incarcerated. Early intervention and diversion will reduce the number initially incarcerated and ongoing services will reduce recidivism. Reducing inappropriate use of justice systems by youth and adults with behavioral health disorders will not only improve the lives of those individuals, but improve overall health and well-being in the Region. Making resources available to provide effective and efficient health care in lieu of incarceration improves quality of life, community health outcomes and criminal justice outcomes. The goals for the program are to: 1) expand the geographic area for services for justice-involved adults and youth; 2) expand the eligibility criteria for participants in the services for justice-involved youth and adults; and 3) implement the project in collaboration with juvenile and adult Court systems and other components of the justice system in the four Counties.

Challenges or Issues Faced by the Performing Provider

A major challenge in carrying out this project will be working with the Courts and other components of the criminal justice systems to identify opportunities for early intervention and diversion. Another challenge is working with those justice systems in four different Counties. Even though someone might be eligible for diversion to treatment, the judicial system must act on that recommendation by dropping charges or taking other legal steps. Judges and prosecutors need to feel confident that treatment will be provided and that it has a reasonable chance of success. Defense attorneys need to have a clear understanding of how diversion is in the interests of their clients.

How the Project Addresses those Challenges

This challenge will be addressed by providing ongoing training and continuing education for jail staff and law enforcement in every County. Communication between BTCS and jail staff, local law enforcement, prosecutors and judges is currently part of the justice-involved intervention program, but is limited to the specialty interventions and special populations or to long-range planning. BTCS currently has offices and operations in all four Counties. We participate in MH Task Forces with key leaders in every County and we will strengthen dialogue with judges, prosecutors, attorneys, adult and juvenile probation by focusing on new services and access for new populations. We will engage in joint implementation planning in each individual County as well as joint treatment planning and presentation of outcome data available so local partners can achieve confidence and fully utilize the services.

How the Project is Related to RHP Goals

This project advances RHP Goal 1- "Prepare and develop infrastructure to improve the health of the current and future Region 7 populations." Goal 2- "Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting." Building infrastructure creates opportunities to live outside of repeated institutional care and receive the right care in the right setting. The project also advances RHP Goal 6- "Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery." The aim of this project is designed to provide assessment and linkage to services to avoid inappropriate incarceration and maintain community living.

Starting Point/Baseline

Baseline Data

Currently BTCS provides some services for the priority population who are also justice-involved in Fayette County and some jail diversion screening, assessment and referral services are provided in the other three Counties. However, neither geographic span of the services nor the eligibility criteria have yet been expanded. Therefore, the baseline census for the new project is 0 in DY 2. Additionally, we have not initiated uniform administration of functional assessments and do not have initial functioning scores.

Time Period for Baseline

The time period for the baseline is DY 2.

Rationale

Reason for Selection of Project Options and Components

Texas has historically utilized the criminal justice system as the default provider of mental health services for adults. As a consequence many individuals with serious and persistent mental illness spend months and years incarcerated for misdemeanors. Texas spends even less on behavioral health services for youth and in recent years juvenile probation departments have had to increase mental health services to meet the growing demand. The jail match data presented above indicate the consequences of limited access to behavioral health services in these Counties. A second consequence is that in the absence of referral and follow-up treatment, individuals are released in the same condition or more deteriorated condition than the one that probably lead to their incarceration. The next time they are detained they are once more mentally ill and/or substance abusing and in jail. An approach based on early identification and treatment will provide more opportunity for successful assimilation into a community setting with ongoing community supports.

Project Components: This project to provide Services to Justice-Involved Youth and Adults – in Bastrop, Caldwell, Fayette and Lee Counties will address all of the required core project components:

a*) Assess size, characteristics and needs of target populations (e.g., people with forensic involvement.)* This project expands services beyond the geographic boundaries of the current program and to a broader group of eligible participants. We have experience and anecdotal information about the target population but more precise assessment is needed. We will access health information including diagnosis and functioning scales for those individuals with criminal justice involvement who have been served in the mental health system and analyze that data for the assessment of size, characteristics and needs.

b) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life. We have familiarity with the literature concerning this program and interventions, but we are adding

clinical services and oversight and will conduct additional reviews. This is also an opportunity to engage community stakeholders in the justice systems to participate in the review, planning and design of the project.
c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes. We will use BTCS justice system quality management staff to facilitate the development and documentation of our evaluation plan. Oversight will be provided by the community stakeholders to ensure measurement of outcomes relevant to the justice systems.
d) Design models which include an appropriate range of community-based services and residential supports. Using the information from stakeholders, evaluation metrics, patient assessments and reports; we will evaluate available interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.
e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. The impact of interventions will be assessed on an individual patient level by using the ANSA for adults, the CANS for youth and the SF 36. Aggregated data from those assessments along with number of juvenile referrals or adult incarcerations will be used to assess community impact and identify and respond to lessons learned.

Reason for Selection of Milestones & Metrics For DY 2 we selected P-1 "Conduct needs assessment of complex behavioral health population and identify expanded population of youth and adults who are frequently admitted to criminal justice settings/frequent users of community public health resources " and P-3 "Enroll and serve individuals with targeted complex needs, forensic involvement." We made these selections because we need to understand the new population and the demand of that population because there is clearly a great need to initiate services. We will conduct a PDSA cycle as indicated by process milestone for DY 3 and utilize the information concerning enrollment and demand and as we begin to track increase in service volume to this special population. Improvement milestone selected for DY 4 and 5 is Improvement Milestone I-X for Target Population Reached. We expect to serve an additional 100 people in DY4 and 150 in DY5. Improved access in this new program will support the outcome Measure selected. We will measure and report reduction in criminal justice involvement for Category 3. We selected target population Reached, because without access to these community based services, this group of patients cannot achieve and maintain community tenure. Access directly reduces recidivism and will lead to a reduction in criminal justice involvement.

Unique Community Need Identification Number
CN.4 – Inadequate access to behavioral health care; and CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative
Currently BTCS provides behavioral health care only to adults with serious mental illnesses and or youth with severe emotional disturbances. There are no licensed substance abuse programs in the Counties. This project continues the current direction of improving access in rural areas, for low income individuals and for everyone who requests and needs services.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
BTCS receives funds from US Department of HHS including Substance Abuse Prevention and Treatment Block Grant used to operate substance abuse Outreach Screening and Referral services in these four counties and several other counties; and Community Mental Health services block grant used for outpatient mental health services. The service provided in this project is case management and linkage to services, but **no Federal Funds other than**

those for DSRIP will be used in this project. Participants could be referred and treated in those other programs ongoing or upon discharge. This project improves access to those services that will be needed as these individuals are diverted from incarceration and provided behavioral health care in the community.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-9 Right Care, Right Setting
IT- 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.

Reasons/Rationale for Selecting the Outcome Measure(s)
Providing community care at the right time and in the right setting and thereby reducing inappropriate arrest and incarceration will lead to productive and contributing youth and adults. We believe that achieving the project goal and providing early intervention and treatment leads directly to the outcome of right care, right setting. Allowing people to languish in jail due to mental illness or substance abuse is wrong and counterproductive for them and for our society.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects
As described above, case managers must have referral options and the proposed projects create those options and provide the opportunity for successful community life. The proposed projects include: Outpatient Addiction Services; Youth Counseling, Primary/Behavioral Health Care Integration, Transitional Housing and Child Crisis Respite.
List of Related Category 1 & 2 Projects (in the order listed above)
126844305.1.3; 126844305.1.1; 126844305.2.4; 126844305.2.1; and 126844305.1.2
List of Related Category 4 Projects *(RHP Project ID Number)*
N/A
Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects
186599001.1.1: School Campus Counseling
133340307.2.6: Children's Mental Health Crisis Center

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
We plan to participate in learning collaboratives related to our projects organized or initiated by the RHP 7 Anchor entity, Central Health. We also plan to develop a learning collaborative related to this specific project with the other community mental health centers in RHP 7 proposing the same project for different counties. Additionally, we have participated in learning collaboratives through the Texas Council of Community Centers.

Project Valuation

Approach for Valuing Project

We expect to serve an additional 100 people in DY4 and 150 in DY5. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this project, in which people work toward their optimum level of recovery and independence, the cost utility of that community tenure is one gauge of value along with system health care costs and specific health system benefits. This method allows us to compare these disparate elements.

126844305.2.3	***2.13.1***	***2.13.1 (a - e)***	***Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Services for Justice-Involved Youth and Adults: Bastrop, Caldwell, Fayette and Lee Counties***	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services				*126844305*
Related Category 3 Outcome Measure(s): OD-9	*126844305.3.6*	*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-1]: Conduct needs assessment of complex behavioral health population and identify expanded population of youth and adults who are frequently admitted to criminal justice settings/frequent users of community public health resources **Metric 1**: [P-1.1]: Provide report identifying the following: - Targeted population characteristics - Gaps in services - How program will identify, prioritize and manage target population - Ideal number of patients to enroll - Estimate of resource adequacy related to services and locations - Demographics - Diagnoses	**Milestone 3:** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles. Baseline/Goal: Meet Monthly to review data and conduct improvement assessments and set goals. Data Source: Project reports (including data sets,) Agendas, Minutes, sign-in logs Milestone 3 Estimated Incentive Payment: $227,369		**Milestone 4** [I-X]: Number of patients served **Metric 1** [I-X.1]: Target population reached; number of patients served who have been involved with law enforcement and the judicial system who also has a behavioral health issue. **Baseline/Goal:** Baseline for this new community based program is 0 for DY 2/ Goal: Expect to serve 100 in DY4 **Data Source: EHR** Milestone 4 Estimated Incentive Payment: $242,857	**Milestone 5** [I-X]: Number of patients served **Metric 1** [I-X.1]: Target population reached; number of patients served who have been involved with law enforcement and the judicial system who also has a behavioral health issue. **Baseline/Goal:** Baseline for this new community based program is 0 for DY 2/ Goal: Expect to serve 150 in DY4 **Data Source: EHR** Milestone 5 Estimated Incentive Payment: $234,806

- Housing status - Functional and cognitive issues - Medical utilization **Goal:** Produce a comprehensive report documenting all points above. **Data Source:** Project documentation; stakeholder surveys, criminal justice assessments and records. **Milestone 1 Estimated Incentive Payment (maximum amount): $104,866** **Milestone 2**: [P-3]: Enroll and serve individuals with targeted complex needs, forensic involvement. **Metric 1**: [P-3.1]: Number of targeted individuals enrolled / served in the project. **Baseline/Goal:** Baseline is 0/ goal is 25 enrolled and served in DY 2. **Data Source:** Project documentation; criminal justice records and EHR. **Milestone 2 Estimated Incentive Payment (maximum amount): $104,866**			

Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $209,732	Year 3 Estimated Milestone Bundle Amount: $227,369	Year 4 Estimated Milestone Bundle Amount: $242,857	Year 5 Estimated Milestone Bundle Amount: $234,806
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $914,764			

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Primary Care / Behavioral Health Care Integration Clinic – Caldwell County
Project Identifier: 126844305.2.4 Pass 2

Provider: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7 and for four other Counties in nearby RHPs. We are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. We are the only provider of public behavioral health services in these four mostly rural Counties with a population of 153,403.

Intervention(s): We propose to establish a primary care / behavioral health care clinic site in Lockhart, Texas and to operate this clinic together with the FQHC, Community Health Centers of South Central Texas (CHCSCT,) creating an integrated system of health care. BTCS provides specialty behavioral health services to the poor and underinsured or uninsured of Caldwell County. CHCSCT provides the underserved and underinsured or insured of Caldwell County with primary medical, dental and behavioral health services.

Need for the project: According to the Community Needs Assessment (CNA) published by RHP7, page 13, "Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition. Moreover, almost 59% of Travis County patients with a mental health diagnosis also experienced a co-occurring medical condition. An additional 20% had a substance abuse disorder, including 13% that had tri-morbid conditions (mental health, substance use disorder, and medical condition)."National surveys indicate that more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder had a comorbid mental health condition. This addresses RHP 7 Community Needs Assessment needs: CN.1 – Inadequate access to primary care; CN.3 – Inadequate access to dental care; CN.4 – Inadequate access to behavioral health care; and CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues; CN.10 – Many residents in Region 7 have multiple chronic conditions; CN.15 – Additive and costly impact of co-occurring mental health, substance abuse and medical conditions.

Target population: The target population is adults and youth who are in need of a medical home and are poor, under or uninsured. We expect to serve over 1,000 individuals when the project is underway. BTCS served over 7,769 with behavioral health disorders in FY 2012. An average of 43% of adults were eligible for Medicaid; 76% of youth were eligible for CHIP or Medicaid and 73% of BTCS clients are below the federal poverty level. Approximately 70% of those benefitting from this project will be poor, under or uninsured.

Category 1 or 2 expected patient benefits: The improvement milestone is an unduplicated count of the target population reached.. This project seeks to serve 3,000 in DY 4 and 4,000 in DY 5. We expect those services to be an as yet undetermined mix of primary care, dental and mental health.
Category 3 outcomes:

- IT-1.8 Our goal is for 30% in DY 4 and 50% in DY 5 to be screened for clinical depression and have treatment plan initiated if applicable.
- IT-1.9 Our goal is to achieve improvement on a standardized depression scale of 20% in DY 4 and 30% in DY 5 of persons treated for 12 months.

Title of Project: Design, implement, and evaluate project that provides integrated primary and behavioral health care services: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County
Category / Project Area / Project Option: 2.15.1
RHP Project Identification Number: 126844305.2.4 Pass 2
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Performing Provider TPI: 126844305

Project Description

Overall Project Description

This project addresses the need to improve access to behavioral health services and primary care in Caldwell County, specifically in the north central portion of the county, Lockhart, Texas. Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Bastrop, Caldwell, Fayette and Lee Counties in RHP 7 and for four other Counties in nearby RHPs. In that capacity we are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. BTCS has been working collaboratively with Community Health Centers of South Central Texas (CHCSCT) since 2008. CHCSCT is a community based non-profit Federally Qualified Health Center (FQHC) headquartered in Gonzales, Texas and with a Community Health Center site located in Luling on the southern border of Caldwell County. We propose to establish a primary care / behavioral health care clinic site in Lockhart, Texas and to operate this clinic together, creating an integrated system of health care. BTCS provides specialty behavioral health services to the poor and underinsured or uninsured of Caldwell County. CHCSCT provides the underserved and underinsured or insured of Caldwell County with primary medical, dental and behavioral health services. According to the Community Needs Assessment (CNA) published by RHP7, page 13, "Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition. Moreover, almost 59% of Travis County patients with a mental health diagnosis also experienced a co-occurring medical condition. An additional 20% had a substance abuse disorder, including 13% that had tri-morbid conditions (mental health, substance use disorder, and medical condition)." We assume the prevalence extends into Caldwell County based on national data, "Comorbidity between mental and medical conditions is the rule rather than the exception. In the 2003 National Comorbidity Survey Replication (NCS-R), more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder had a comorbid mental health condition," ('Mental disorders and medical comorbity;' Goodell, et al., February 2011.) There is good evidence that the most effective treatment for persons with comorbid mental and medical conditions involves a collaborative care approach. (Gilbody, et al.,JAMA, 289, 3145– 3151; 2003.) We plan to use the collaborative care model described by the Hogg Foundation, "in which physical health and mental health providers partner to manage the treatment of mild to moderate psychiatric disorders and stable severe psychiatric disorders in the primary care setting". BTCS and CHCSCT integrated clinic site will include a full range of behavioral health services for adults, adolescents and children. This will be accomplished by using some current staff and recruiting additional staff to include: psychiatrist, LPC or LCSW, nurse, health care coordinator, etc.

CHCSCT will recruit and train primary care providers, dental providers and ancillary staff. When operational we should have capacity to serve ~~1,000~~ 4,000 low-income patients per year.

Project Goals

The overriding goal of CHCSCT and BTCS is that persons with mental illness will have better quality of life due to increased access and linkage to primary medical, dental and behavioral health services. Other goals include:

- Improved communications and trust among patients and their mental health, primary care medical and dental providers.
- Increased availability of screening, diagnosis, and guidance for mental health patients with a history of non-compliance with medication, high no-show rates, multiple visits to the emergency room for primary care problems, and/or repeated hospitalizations for the same reason.
- Reduced length of time to access treatment, resulting in reduced symptoms and clinically significant improvement.

These goals are part of an effort to have persons with mental illness consider CHCSCT their medical home.

Challenges or Issues Faced by the Performing Provider

A major challenge facing BTCS and CHCSCT is to continue to integrate the data systems and the cultures of the two organizations so that they can provide true collaborative care. Two other challenges will be achieving utilization of the new clinic and recruiting and retaining qualified providers in this rural County.

How the Project Addresses those Challenges

As stated above, BTCS and CHCSCT have been collaborating since 2008 and have operated a clinic site together in another county since 2010. The next steps to further integrate the agencies include completing information systems sharing and forming a performance improvement committee to measure progress in clinical performance measures. The development of protocols for this project and the PDSA cycles planned for DY 3 will help address the first challenge. Utilization of the clinic will start with current BTCS patients in Caldwell County who do not have a primary care provider. Additionally, CHCSCT and BTCS produce brochures, newsletters and news releases. Both have websites and Facebook pages. We will use these media to educate and inform the public about the services. Finally, both BTCS and CHCSCT have well established reputations in the Region and will use this to recruit providers within their separate areas of expertise. BTCS has capacity to use telemedicine to supplement psychiatric coverage as needed and both will offer additional stipends and incentives if needed.

How the Project is Related to RHP Goals

This project advances RHP Goal 1- "Prepare and develop infrastructure to improve the health of the current and future Region 7 populations; Goal 2- "Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting;" Goal 3 – Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems; Goal 4 – "Bolster individual and population health by improving chronic disease management;" and Goal 6- "Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery." The aimof this project is to provide integrated care and improve health outcomes, reduce cost and improve patient satisfaction with care. Building infrastructure creates opportunities to access the right care in the right setting and give patients the resources to live healthy productive lives.

Starting Point/Baseline

Baseline Data

Currently BTCS and CHCSCT do not operate an integrated clinic in Lockhart, Texas; therefore, the baseline census for the new project is 0 in DY 2.

Time Period for Baseline

The time period for the baseline is DY2.

Rationale

Reason for Selection of Project Options and Components

This integrated healthcare delivery strategy has been selected to ensure that the individuals receive the right care As stated above, the Regional CNA revealed that almost 59 percent of Travis County patients with a mental health diagnosis also experienced a co-occurring medical condition and national data confirms this is not an issue exclusive to Travis County. Realization of the true cost and impact on health outcomes is also growing. "There is increasing acknowledgment that mental health disorders are as disabling as cancer or heart disease in terms of lost productivity and premature death…A comprehensive health care system must support mental health integration that treats the patient at the point of care where the patient is most comfortable and applies a patient-centered approach to treatment. Integration is also important for positively impacting disparities in health care in minority populations." Evolving Models of Behavioral Health Integration in Primary Care; Collins, et al.,2010. Caldwell County is designated as Health Professions Shortage Area and as Medically Underserved Area. Per the 2010 census there are 25.2% uninsured in Caldwell County and 19.6% are living below the federal poverty level. CHCSCT serves the following demographics: 80% of patients are at 200% of poverty or below; 59.3% are uninsured; and 62% Hispanic, 27% White, and 7% Black. 73% of BTCS clients are below the federal poverty level; 55% are uninsured; and 36% Hispanic, 38% White, and 26% Black. CHCSCT and BTCS understand integrated health care to be the process of eliminating gaps in shared information and communication. We believe that integrated care is more than the physical location or co-location of primary care, behavioral health and other specialty services. It refers to the delivery of comprehensive, coordinated services with good communication among providers. Patient involvement is a key to treatment. Integrated health care provides a high quality, multidisciplinary approach to delivering patient-centered services in a cost effective manner. A FQHC, as a high quality primary care provider, can manage the delivery of seamless, well-coordinated care as the patient's medical home

Components of this project include:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant a number of patients in the community. BTCS has located a facility in Lockhart, Texas and is prepared to begin renovation to establish the space needed for the integrated clinic. We have identified other funds for the renovation and will not use DSRIP funding to carry out the changes. No capital investment will be made with DSRIP funds. We feel that this component has been addressed.

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. CHCSCT and BTCS have been collaborating since 2008. A Memorandum of Understanding was signed by the two agencies in 2012 updating a 2009 agreement. Coordination of care can proceed with all other providers without formal agreements.

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers. Since BTCS and CHCSCT currently operate a clinic site together, protocols and processes have

been developed and implemented. We will refine those for this site and continue to improve them for all sites.

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations. BTCS will recruit behavioral health providers and staff for this new clinic location as well as using telemedicine to supplement provider coverage; and CHCSCT will recruit, employ and train the primary care team including PCPs, OB/Gyn, Pediatrics and Dental providers.

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing. The project will focus on ensuring that patients receive services that are evidence based. The approach will involve developing an individual and collaborative care plan for each participant. Through integration CHCSCT will be able to provide its patients with quick access to mental health services and BTCS patients will access medical and dental services – removing barriers to access to the full spectrum of healthcare services for the whole community.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project. BTCS and CHCSCT co-locate at another site and will continue to work on the integration of the health record. Currently we are planning for use of a shared health information system allowing more seamless access to patient information for our providers of integrated services.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice. We will continue to evaluate the current MOU and assess for future needs in this area.

h) Arrange for utilities and building services for these settings. As stated above, BTCS is prepared to outfit and manage the physical plant.

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings. BTCS is a member of the health information exchange in its region. We will continue to work with that entity to implement data reporting.

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

CQI activities will focus on rapid cycle process improvements to ensure that clinical care, clinic processes and communication is optimized. We plan to build on the work from our prior collaborative care implementation. Reports will be produced and consultations with all team members will be utilized to discuss outcomes, potential for improvement and successes.

Reason for Selection of Milestones & Metrics We selected the process milestones P-3 for DY 2 because have a location for the clinic and experience operating collaborative care. The Metrics selected are P-3.1 and P-3.3 because we expect adherence to the established referral protocol. We also selected P-5 for DY 2 because we will need to enter into a signed agreement to begin development of the project. We selected P-6 or DY 3 with metric P-6.1 because have experience with integrated sites, this is a new location with new staff and will need training and process improvement. We will achieve collaboration but we expect the site to be only partially integrated. We also selected P-7 for DY 3 because we will conduct a PDSA cycle as indicated above to build collaboration, communication and true integration. Improvement milestone selected is I-X the number of persons in the Target Population reached. We expect to serve 3,000 people in DY 4 and 4,000 People in DY 5 at this integrated site.

Unique Community Need Identification Number

CN.1 – Inadequate access to primary care; CN.3 – Inadequate access to dental care; CN.4 – Inadequate access to behavioral health care; and CN.6 – Inadequate services throughout the continuum of care for individuals with behavioral health issues; CN.10 – Many residents in Region 7 have multiple chronic

conditions; CN.15 – Additive and costly impact of co-occurring mental health, substance abuse and medical conditions.

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

Currently BTCS and CHCSCT provide co-located and integrated care in Gonzales, Texas. We have a joint project underway through a grant from the Health Services Resource Administration (HRSA) to build and establish an integrated clinic adjacent Guadalupe County in Seguin, Texas. This project would continue the current direction of BTCS and provide integrated care; and to improve access in rural areas, for low income individuals and for everyone who requests and needs services.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

BTCS receives funds from US Department of HHS including Substance Abuse Prevention and Treatment Block Grant used to operate substance abuse Outreach Screening and Referral services in these four and several other counties; and Community Mental Health services block grant used for outpatient mental health services. CHCSCT receives a Federal 330 grant for other areas in which it operates. No Federal Funds other than DSRIP funds will be used to establish and operate this project. We plan to bill and collect Medicaid, Medicare, enhanced rate Medicaid and other third party sources, but will not use CMH block Grant or FQHC grant funds in this project. Participants could be referred and treated in those other programs ongoing or upon discharge.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-1- Primary Care and Chronic Disease Management

IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression

IT-1.9 Depression management: Depression Remission at Twelve Months

Reasons/Rationale for Selecting the Outcome Measure(s)

Analysis of a national claims database with respect to 10 common chronic conditions revealed that the presence of comorbid depression or anxiety significantly increased total health care costs (Melek and Norris). Depression may decrease the motivation and energy needed to perform self-management behaviors and may adversely impact interpersonal relationships, including collaboration with physicians (Katon WJ. *Biological Psychiatry,* vol. 53, no. 3, 2003.). The odds of noncompliance with medical treatment regimens are three times greater for depressed patients compared with non-depressed patients (DiMatteo, et al., *Archives of Internal Medicine*, vol. 160, no. 14, 2000.) Clearly, identification and treatment of depression will improve healthcare quality, cost and effectiveness.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This project will use and support other proposed projects: Outpatient Addiction Services; Youth Counseling, Transitional Housing, Child Crisis Respite and Services for Justice-Involved Youth and Adults. This project will refer to those services and take referrals from them to provide whole health care for participants, thereby creating the opportunity for successful community life.

List of Related Category 1 & 2 Projects (in the order listed above)

126844305.1.3; 126844305.1.1; 126844305.2.1; 126844305.1.2; and 126844305.2.3

List of Related Category 4 Projects *(RHP Project ID Number)*
N/A

Relationship to Other Performing Providers' Projects in the RHP
List of Other Providers in the RHP that are Proposing Similar Projects
133542405.2.1: Integrate Primary and Behavioral Health Care Services
133542405.2.5: Implementation of Chronic Disease Prevention/ Management Models
133340307.1.1: Hays County Mental Health Center Mobile Clinic
307459301.2.3: Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients
307459301.1.3: Mobile Primary Care

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
We plan to participate in learning collaboratives related to our projects organized or initiated by the RHP 7 Anchor entity, Central Health. We also plan to develop a learning collaborative related to this specific project with the other community mental health centers in RHP 7 proposing the same project for different counties.

Project Valuation

Approach for Valuing Project
This project seeks to establish this new integrated healthcare site and serve 3,000 in DY 4 and 4,000 in DY 5. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this project, in which people work toward their optimum level of recovery and independence, the cost utility of that community tenure is one gauge of value along with system health care costs and specific health system benefits. This method allows us to compare these disparate elements.

126844305.2.4	***2.15.1***	***2.15.1 (a-j)***	***Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.***
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 3 Outcome Measure(s):	*126844305.3.7* *126844305.3.8*	*IT-1.8* *IT-1.9*	***Depression management: Screening and Treatment Plan for Clinical Depression*** ***Depression management: Depression Remission at Twelve Months***

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. **Metric 1**: [P-3.1]: Number and types of referrals that are made between providers at the location. **Goal:** 25% of Referrals between providers are internal and appropriate to provider type. **Data Source:** Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results. **Metric 2**: [P-3.3]: Number of referrals which follow the established standards. **Goal:** 10% of Referrals between providers are internal and appropriate to provider type. **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**	**Milestone 3:** [P-6]: Develop integrated behavioral health and primary care services within co-located sites. Metric 1: [P-6.1] Number of providers achieving Level 4 of interaction Baseline/Goal: 50% of providers achieve Level 4 interaction Data Source: Project data and EHR for BTCS and CHCSCT Milestone 3 Estimated Incentive Payment: $2,236,291 **Milestone 4:** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services. Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles. Baseline/Goal: Meet Monthly to review data and conduct improvement assessments and set goals.	**Milestone 5:** [I-X]: Target population reached Metric 1: [I-X.1]: Number served at this integrated site in the target population. Baseline: There was no site in DY 2 therefore the baseline is 0 Goal: 3,000 in DY 4 in this integrated site. Data Source: Project data; claims and encounter data; and EHR. Milestone 5 Estimated Incentive Payment: $4,777,252	**Milestone 6:** [I-X]: Target population reached Metric 1: [I-X.1]: Number served at this integrated site in the target population. Baseline: There was no site in DY 2 therefore the baseline is 0 Goal: 4,000 in DY 5 in this integrated site. Data Source: Project data; claims and encounter data; and EHR. Milestone 6 Estimated Incentive Payment: $4,618,889

Payment (maximum amount): $2,062,827 **Milestone 2:** [P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project: **Metric 1: [**P-5.1]: Number of agreements signed for the provision of integrated services; **Goal**: Sign one agreement. **Data Source:** Project data **Milestone 2 Estimated Incentive Payment (maximum amount): $2,062,826**	Data Source: Project reports (including data sets,) Agendas, Minutes, sign-in logs Milestone 4 Estimated Incentive Payment: $2,236,291		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $4,125,653	Year 3 Estimated Milestone Bundle Amount: $4,472,582	Year 4 Estimated Milestone Bundle Amount: $4,777,252	Year 5 Estimated Milestone Bundle Amount: $4,618,889
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $17,994,376			

City of Austin Health and Human Services Department (HHSD)
Category 2 DSRIP Projects

City of Austin Health and Human Services Department (HHSD)
Provide ACT Model for Participants of Housing First Permanent Supportive Housing
201320302.2.1 - Pass 1

Provider: City of Austin Health and Human Services Department is the local health authority that has public health jurisdiction over Austin/Travis County with a population of 1,024,266 residents. The Department has two immunization clinics, one refugee clinic and one STD clinic. In addition, the Department provides preventive health services, programming and education; policy, systems, and environmental health recommendations; emergency preparedness and response; neighborhood center operations and contracting for social services with community agencies.

Intervention(s): The City of Austin's Health and Human Services Department (HHSD) proposes providing an **Assertive Community Treatment (ACT)** team to recently housed individuals (housed through a non-profit housing provider) who were chronically homeless and who have tri-morbid conditions, meaning that they have co-occurring psychiatric, substance abuse, and chronic medical condition and are in need of additional support systems. These individuals will be housed in Housing First (HF) Permanent Supportive Housing (PSH) in the community.

Need for the project: Currently, there are only 26 HF PSH units in Austin; however, none of these incorporate an ACT team as described in this project. This innovative approach will address these vulnerable and costly individuals and help them maintain housing stability and improved quality of life via the medical services provided by the ACT team, which will not only benefit each person but the community at large.

Target population: The ACT model that we propose implementing in Austin will assist approximately 15 single adult men and women who have experienced chronic homelessness, severe and persistent mental illness (SPMI), co-occurring substance abuse, and who have been recently placed in deeply subsidized housing despite significant physical and behavioral health (BH) challenges.

Category 1 or 2 expected patient benefits: The expected outcome for Cat 2 is that 20% of these participants will adhere to anti-depressant medication management over six months for Major Depressive Disorder and anti-depressant medication during acute phase over 12 weeks.

Category 3 outcomes: Our Cat 3 outcome domain "OD-9 Right Care, Right Time" and improvement measure IT9.2 "ED Appropriate utilization" were selected because evidence shows[19] that when vulnerable people, such as the chronically homeless, are connected with appropriate medical care, such as an ACT team, they are far less likely to utilize costly public services, such as jails, EDs, and EMS[20]. We expect a 20% decrease in inappropriate ED use by DY 5.

[1,2,3]Http://www.nami.org/Template.cfm?Section=ACTA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=52382

Title of Project: **Provide ACT Model for Participants of Housing First Permanent Supportive Housing**
Category / Project Area / Project Option: **2.13.1: Design, implement and evaluate research-supported evidence based interventions tailored towards individuals in the target population**

RHP Project Identification Number: **201320302.2.1 Pass 1**

Performing Provider Name: **City of Austin Health and Human Services**

Performing Provider TPI: **201320302**

Project Description

Overall Project Description

The City of Austin's Health and Human Services Department (HHSD) proposes providing an **Assertive Community Treatment (ACT)** team to recently housed individuals (housed through a non-profit housing provider) who were chronically homeless and who have tri-morbid conditions, meaning that they have co-occurring psychiatric, substance abuse, and chronic medical condition and are in need of additional support systems. These individuals will be housed in Housing First (HF) Permanent Supportive Housing (PSH) in the community. This DSRIP project will henceforth be referred to as HF ACT, and the terms participants and patients will be used interchangeably.

This project will enhance the City of Austin's existing PSH strategy (developed in 2010) by providing expanded ACT services to men and women in need of this type of comprehensive care. These individuals will already be housed through a housing program, with rent often subsidized by local housing authorities, HUD, foundation grants, or by other means.

Population targeted: The ACT model that we propose implementing in Austin will assist single adult men and women who have experienced chronic homelessness, severe and persistent mental illness (SPMI), co-occurring substance abuse, and who have been recently placed in deeply subsidized housing despite significant physical and behavioral health (BH) challenges. According to Metro Crisis Services, SPMI is "used to describe schizophrenia, schizoaffective disorder, recurrent major depression and bipolar disorder. The word 'severe' refers to degree to which the illness may disrupt a person's normal life activities. The word 'persistent' refers to the long duration of these illnesses."[21] Because of the severity of these conditions, these homeless individuals are often identified as the most vulnerable and in need of the most comprehensive wrap around services.

ACT Model: The ACT model utilizes a ***multi-disciplinary team***, which can consist of outreach team members, registered nurses, case managers, psychologists or psychiatrists, and/or a primary care physician. PSH participants will also be connected with a medical home and provided respite care if necessary. ***Treatment*** is another important component of the ACT model, and includes psychopharmacologic treatment, including new atypical antipsychotic and antidepressant medications, individual supportive therapy, mobile crisis intervention, and substance abuse treatment, and group therapy (for participants with a dual diagnosis of substance abuse and mental illness).[22] Furthermore, ***rehabilitation,*** such as behavior oriented skill teaching (supportive and cognitive-behavioral therapy) and support for resuming

[21] http://www.metrocrisisservices.org/7-learn-more/glossary#S

[4,5,6] http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=132547

education and employment[23], are critical components. Due to the vulnerable nature of these participants, these services are available 24/7/365.[24]

Core Components

Core Component a) under project 2.13.1 was completed in Austin when the 100 Homes Campaign, which surveyed and identified Austin's most vulnerable homeless individuals and families[25], was conducted in Nov 2011. Component b) has been implemented in Austin through various agencies that work with this population. However, a more thorough and rigorous literature/best practice review will be incorporated during the planning phase of this project. Component c) will be also be developed during the planning stage of this project. Component d) has been completed, for we know that the best model to use for this population incorporates comprehensive and holistic services, which ACT provides. Component e) will be implemented throughout the project, from inception to completion. Quantitative data, such as prescription drug and claims/encounter records, will be collected by the ACT team members. Qualitative data, such as patient interviews, will also be collected. In DY 4 and 5, the opportunity to scale all or part of the intervention to a broader patient populations will be assessed. In addition, we will implement the following community based components in this project to the best of our ability - supported employment, home delivered meals, transition assistance, prescription medications, substance abuse services, and visiting nursing and / or community health worker services.

Project Goals

Broadly speaking, the goal of HF ACT is for participants to achieve housing stability, connect to a medical home, and ultimately live healthy, happy lives. Other goals will include avoiding hospital inpatient re-admissions, averting involvement in the criminal justice system, promoting wellness and medication adherence, and ultimately, substance abuse recovery."[26]

Specifically, our goal over the next four years is to keep people housed by addressing complex psychological and medical needs by reducing incidents of substance use, managing chronic diseases, and addressing BH issues. This is accomplished through the use of multidisciplinary teams of BH specialists, case managers, and medical staff, such as registered nurses and/or PCP.

The five year expected outcome is that 20% of participants will remain on anti-depressant medication.

Challenges or Issues Faced by the Performing Provider

Implementation Challenges:

This DSRIP project presents a few challenges, such as the need to connect these individuals with appropriate medical and BH care, as well as the fact that the three components of this project (HF, PSH and ACT) have not been implemented as one project before in Austin. However, the biggest challenge we anticipate is working with a difficult population. Some of these challenges may include helping the participants adjust to living in housing, medication management, transportation, and cooperation in the program. However, anecdotal evidence from PSH providers suggest that once the stress of being homeless

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[25] http://www.100homesaustin.org/

[26] http://www.hhsc.state.tx.us/1115-docs/RHP/Category-2-RHP.pdf p.300

has been eased (through housing) and when basic needs are met, participants are willing and able to participate in programs such as ACT.

How the Project Addresses those Challenges

Though components of this project have been implemented in Austin before, combining all three (HF, PSH, and ACT) together in one project has yet to be been done. However, based on the desire and ability of providers in working with this population, we believe that this is a very manageable and promising model. While new learning collaboratives will be implemented with the rollout of this project, there are also current collaborations which will make this project feasible, such as ECHO (Ending Community Homelessness Coalition). ECHO is comprised of 90 community members monthly from local non-profits, businesses and government, with the goal of developing, prioritizing, and promoting strategies to prevent and end homelessness.[27] Additionally, City of Austin employees in Neighborhood Housing and Community Development and Health and Human Services are fostering relationships with EMS, Seton Family of Hospitals, St. David's Foundation, and other key healthcare providers to better understand and provide for the target population. Progress is also continually being made with various stakeholder groups in regards to HF and PSH. For example, the Downtown Austin Alliance (DAA) has accepted and actively supports the CoA's PSH strategy, particularly for the most vulnerable, medically fragile, and hardest to serve chronically homeless. Additionally, the potential challenges with participants mentioned above can be resolved with appropriate, professional, well equipped, and experienced ACT team members. Lastly, while the ultimate goal of this project is to connect individuals to appropriate medical and BH care, providing them with safe, secure, and affordable housing *first* is the lynchpin of success for this project. For this population, housing alone is not enough. The services provided through this DSRIP project are what will make this model a success for both the individual as well as the community.

How the Project is Related to RHP Goals

This project aligns with each of Region 7's RHP goals because it prepares and develops infrastructure through (Goal 1) the ACT team, reduces healthcare costs (Goal 2) by aligning patients with more appropriate behavioral and physical health care providers, improves the patient experience (Goal 3) because ACT is a patient-focused method, assist patients in managing chronic diseases, provides BH (Goal 6) and PH education, promotes recovery through individual treatment, and increases quality of life by ensuring that vulnerable individuals are housed in safe and secure housing.

Starting Point/Baseline

Baseline Data

Currently, there are only 26 HF PSH units in Austin, however none of these incorporate an ACT team as described in this project. Therefore, the baseline for this project is 0. Data is and will be collected through our Homeless Management Information System (HMIS), which is managed by the Ending Community Homelessness Coalition (ECHO).

Rationale

Reason for Selection of Project Options and Components

Though Austin is a thriving and vibrant city, we still struggle with high rates of poverty and homelessness. According to the 2011 Point in Time Count (PIT), there were 2,362 people experiencing homelessness in

[27] http://www.austinecho.org/

Austin/Travis County[28]. Of these 2,362 individuals, 785 were identified as being chronically homeless[29], 501 as severely mentally ill, and 781 as having a chronic substance abuse disorder.[30]
This HF ACT program would be the first of its kind in Austin to work with this specific population (tri-morbid formerly homeless individuals). Systems of care have not been able to provide this model before due to lack of funding and understanding of the complexities of this population (CN16). However, significant progress has been made recently in understanding that medically fragile and vulnerable chronically homeless must be prioritized in our plan to end homelessness[31].
Additionally, recent analysis in the community has shown that 69% of people who were admitted to the hospital four or more times within 30 days were homeless. Of these homeless patients, 38% had bipolar disorder, 31% had schizoaffective disorder, 31% had major depression, and 92% co-occurring substance use. These patients stayed in the hospital an average of 44 days, averaging approximately $368,000 in total hospital costs per individual. [32] We believe that this ACT program will help reduce these types of readmissions because the patients will be connected with a medical home and PCP and learn about medication management, as well have case managers to assist with any BH or substance use crises that may arise.

Furthermore, this represents a departure from past models, where these individuals needed to navigate the medical system on their own and find their way (both physically and emotionally) to various agencies and services located at numerous locations (CN6). This often resulted in the person missing appointments, being dropped from caseloads, or losing prescriptions, etc. Ultimately, many of these individuals thus gave up and resorted to using 911, EMS, and the ED for all of their medical needs, regardless of the severity or urgency of condition (CN8). Unfortunately, this also led to a lack of preventative and routine care, therefore resulting in much more (and often preventable) serious injuries and illnesses.
This population is also one of the costliest to tax payers as they are often uninsured, yet use the most expensive emergency services and institutions, which include jails/prisons, courts, emergency physiatrist services, and homeless shelters (CN16).

Based on these needs and statistics, this innovative approach will address vulnerable and costly individuals and help them maintain housing stability and improved quality of life via the medical services provided by the ACT team, which will not only benefit each person but the community at large. Furthermore, this DSRIP project aligns with components in each of the strategies found in Central Health's Desired Continuum of Care pyramid[33] as well as Senator Kirk Watson's "10 in 10 Goal" plan, specifically #7: Provide needed behavioral health services and facilities[34].

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[28] http://www.hudhre.info/CoC_Reports/2011_tx_503_pops_sub.pdf

[29] http://www.hudhre.info/documents/2012HICandPITGuidance.pdf

[30] However, it is important to note that over 9,000 unduplicated people were served in Austin's Homeless Management Information System (HMIS) last year, so the PIT number is considered to be very conservative.

[31] http://www.100homesaustin.org/

[12, 15] "Frequent Utilization of Behavioral Health Services in Various Service Systems", Presented by Mental Health Task Force in August 2011

[33] http://texasregion7rhp.net/wp-content/uploads/2012/06/Behavioral-Health-Pyramid-Framework-04.11.12.pdf

[34] http://www.healthyatx.org/learn/10-in-10/

Reason for Selection of Milestones & Metrics

Milestone 1 (P-2) was selected because there is a community need (CN.8) to design an intervention program, such as the ACT model, for homeless individuals who frequently and inappropriately use EMS and EDs. We expect that the first year (DY2) will consist of designing the ACT program, which will include posting a Request for Application (RFA), selecting an agency, hiring ACT team members and begin selection of participants. An RFA is posted because HHSD does not provide direct social services for this type of project. Milestone 2 and 3 (P-3) in DY 3 consist of enrolling and serving participants in the DSRIP project. Based on the complex needs of this population and the lack of adequate care (CN.6) that many have had for years, we anticipate that it will take a full year to successfully enroll all 15 individuals in this program. Milestone 4 (P-5) in DY5 was selected because we understand the importance of meeting regularly and sharing information and best practices to ensure the most successful outcomes for project participants. Milestone 5 (I-4) was selected because we know that at least 30% of homeless individuals who have four or more readmission to the ED suffer from depression[35], so we anticipate that medication management will be a major component of their individual care plans.

Unique Community Need Identification Number

- CN.6: Inadequate services throughout the continuum of care for individuals w/ BH issues
- CN.8: High rates of non-emergent ED usage and potentially preventable inpatient admissions
- CN.15: Additive and costly impact of co---occurring mental health, substance use, and medical conditions

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

This is a new initiative. Though individual components of this DSRIP project have been implemented in the community, this will be the first time that this project incorporates all three components into one project. This is needed because of the high rates of chronically homeless individuals with SPMI and other chronic diseases and the lack of insurance and appropriate housing for this population.

By providing comprehensive medical and BH services to people in their own homes, these individuals will better maintain housing stability, as well as learn how to utilize appropriate medical services (ie. visiting a primary care physician(PCP) instead of an ER for non-emergency situations). This will not only enhance the quality of life for the individual, but will also improve the participant's care, ability to navigate medical services, as well as reduce the cost burden to the community.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

NA

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD- 9 Right Care, Right Setting

IT9.2 – ED Appropriate utilization

Reasons/Rationale for Selecting the Outcome Measure(s)

Outcome domain "OD-9 Right Care, Right Time" and improvement measure IT9.2 "ED Appropriate utilization" were selected because evidence shows[36] that when vulnerable people, such as the chronically homeless, are connected with appropriate medical care, such as an ACT team, they are far less likely to utilize costly public services, such as jails, EDs, and EMS[37]. Additionally, when vulnerable individuals are connected to a medical home and BH providers, and are no longer focused on just providing their immediate basic needs, they can begin to focus on preventative and routine care. Part of this routine care will include anti-depressant medication management, as we know that major depression is extremely common among this population[38]. With a focus on medication management, participants can become stabilized and will thus rely less on emergency room use and more on their ACT team and PCPs. Therefore, their use of EDs will become fewer and more appropriate.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

City of Austin Health and Human Services Department is proposing other projects, but the current project is the only one that focuses on a specific mental health population. The Adult Immunizations (201320302.2.6) project relates through the high risk populations each project serves.

List of Related Category 4 Projects *(RHP Project ID Number): NA*

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Austin Travis County Integral Care (ATCIC) and Bluebonnet Trails Community Services are all proposing projects that will expand BH services for vulnerable populations (133542405.2.2, 133340307.2.3, 133340307.2.2, 133340307.2.4) . These DSRIP projects include, but are not limited to, increased training of BH workforce including professionals and providing early intervention and intensive wraparound services and supports to targeted BH population including individuals with co-morbid substance use disorders (133340307.2.3). These projects will provide a greater continuum of care for homeless individuals with BH issues who are in need of services ranging from early intervention to targeted programs to crisis stabilization to supportive housing services, such as ACT. Other related projects include:

133542405.2.3 - Hospital and Jail Alternative Project: Crisis Residential Program, Development of behavioral health crisis stabilization services as alternatives to hospitalization

126844305.2.2 - Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD); for Bastrop, Caldwell, Fayette and Lee Counties

137265806.2.3 - Substance Abuse Disorder Navigation

137265806.2.4 - - Behavioral Health Assessment and Resource Navigation

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[15,16,17]Http://www.nami.org/Template.cfm?Section=ACTA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=52382

[38] "Frequent Utilization of Behavioral Health Services in Various Service Systems", Presented by Mental health Task Force in August 2011

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year. As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaborative - smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project

Because this population is often uninsured, yet uses the costliest emergency services, there will be a cost avoidance/savings once these high frequent service users are connected to housing and an ACT team. For example, in just three months in 2011, 367 frequent users of EMS (many of whom were or are homeless) requested 6,567 ambulances. During this same time, the top 10 users requested emergency medical transport 831 times. Each of these ambulance visits cost approximately $160, not including unpaid medical bills, which averaged $970 per call[39]. Therefore, by connecting individuals to appropriate medical care, there will be a decreased use of expensive emergency services by uninsured individuals, resulting in cost avoidance/savings to the community at large.

[39] Roser, M. A. (2011, July 5). Austin-Travis County EMS aims to match habitual 911 callers to social services. The Austin American-Statesman.

201320302.2.1	***2.13.1***	2.13.C-E	**Provide ACT Model for Participants of Housing First Permanent Supportive Housing**
City of Austin HHSD			201320302
Related Category 3 Outcome Measure(s):	201320302.3.1	IT-9.2	IT-9.2 ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2. Design community based specialized interventions for target populations. Metric 1 P-2.1. Project plans which are based on evidence /experience and which address the project goals. Baseline/Goal: Develop project plan. Data Source: Project plan documentation such as ACT Team job descriptions, copy of solicitation, and MOUs. Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 237,500	**Milestone 2** P-3. Enroll and serve individuals with targeted complex needs. Metric 1 P-3.1. Number of individuals enrolled/served in project. Baseline/Goal: 50% (7-8 people) Data Source: Project documentation such as copies of leases, individual treatment plans, and ACT Team notes. Milestone 2 Estimated Incentive Payment: $ 112,500 **Milestone 3** P-5. Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1: P-5.1. Metric: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider	**Milestone 4** P-3. Enroll and serve individuals with targeted complex needs. Metric 1 P-3.1. Number of individuals enrolled/served in project. Baseline/Goal: 100% (15 people) Data Source: Project documentation such as copies of leases, individual treatment plans, and ACT Team notes. Milestone 4 Estimated Incentive Payment: $212,000	**Milestone 5** I-4. Anti-depressant medication management over six months for Major Depressive Disorder and anti-depressant medication during acute phase over 12 weeks. Metric 1: 1-4.1 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 anti-depressant medication treatment. Goal: 20% of participants will remain on anti-depressant medication. Data Source: Claims and Encounter Data, ACT Team and individual treatment plan documents Milestone 6 Estimated Incentive Payment: $200,000

201320302.2.1	***2.13.1***	2.13.C-E	**Provide ACT Model for Participants of Housing First Permanent Supportive Housing**	
City of Austin HHSD				201320302
Related Category 3 Outcome Measure(s):	201320302.3.1	IT-9.2	IT-9.2 ED appropriate utilization	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	participated in. Goal: Meet in person or via phone/webinar at least 24 times in 12 months. Data Source: Meeting notes and minutes. P-5.2. Metric: Share challenges and solutions successfully during this bi-weekly Interaction. Goal: 1 new idea proposed each month. Goal: Discuss 1 challenge each month and propose solution. Data Source: Meeting notes and minutes. Milestone 3 Estimated Incentive Payment: $112,500			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $237,500	Year 3 Estimated Milestone Bundle Amount: $225,000		Year 4 Estimated Milestone Bundle Amount: $212,000	Year 5 Estimated Milestone Bundle Amount: $200,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $874,500				

City of Austin Health and Human Services

Expansion of Community Diabetes Project

201320302.2.2 Pass 1

Provider: City of Austin Health and Human Services Department is the local health authority that has public health jurisdiction over Austin/Travis County with a population of 1,024,266 residents. The Department has two immunization clinics, one refugee clinic and one STD clinic. In addition, the Department provides preventive health services, programming and education; policy, systems, and environmental health recommendations; emergency preparedness and response; neighborhood center operations and contracting for social services with community agencies.

Intervention(s): Increase community health workers and/or community-based organizations in the Hispanic and African-American communities that provide culturally appropriate diabetes self-management education.

Need for the project: Analysis of Travis County data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that the prevalence of self-reported diabetes among adults (age 18 years and over) is 6.8% for Travis County[40]. Significant racial and ethnic disparities can be seen in the self-reported prevalence of diabetes as the prevalence among African Americans is 9.2%. The age-adjusted diabetes mortality rate in 2008 for Travis County was 12.1 deaths per 100,000 population. The mortality rates for Hispanics and African Americans were considerably higher, at 37.9 per 100,000 and 49.6 per 100,000 respectively.[41] The risk-adjusted diabetes short-term complications hospital admissions rate was 34.83 per 100,000 population in 2008 and the risk-adjusted diabetes long-term complications admissions rate was 102.16.[42]

Target population: The target population is African Americans and Hispanics with diabetes. Efforts will additionally target medically indigent and Medicaid eligible persons within the target population.

Category 1 or 2 expected patient benefits: The intervention will reach 480 African Americans and Hispanics with diabetes through evidence based diabetes self-management education tailored for these populations that will improve program participants' ability to manage and control their diabetes.

Category 3 outcomes: IT-10.1 Quality of Life assessments will demonstrate a 5% improvement on one or more quality of life measures. Disease management and maintaining good diabetes control is directly related to a person's quality of life and is a predictor of improved health outcomes. [43] Additionally, disease management and self-care training has been shown to improve quality of life. [44]

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[40] BRFSS 2008-2010

[41] DSHS Center for Health Statistics, Texas Health Data. Deaths of Texas Residents 2008. http://soupfin.tdh.state.tx.us/death10.htm

[42] Texas Health Care Information Collection. Texas Hospital Inpatient Discharge Public Use Data File 2008. http://www.dshs.state.tx.us/THCIC/Publications/Hospitals/PQIReport2008/PreventableHospitalizations2008.shtm

[43] http://journal.diabetes.org/diabetesspectrum/00v13n1/pg21.htm

[44] http://www.ncbi.nlm.nih.gov/pubmed/18832286

Title of Project: **Expansion of Community Diabetes Project**

Project Option: **2.6.2 Establish Self-Management Programs and Wellness Using Evidence Based Designs**

RHP Project Identification Number: **201320302.2.2 Pass 1**

Performing Provider Name: **City of Austin Health and Human Services Department**

Performing Provider TPI/TIN: **201320302**

Project Description

Overall Project Description: The Austin/Travis County Health and Human Services (ATCHHSD) has public health jurisdiction over the entire county of 1,024,266 residents, a population that has grown 26% since the year 2000. For the past six years, ATCHHSD has implemented a comprehensive diabetes prevention and control program with funding from both grant and City general funds. Through this program, diabetes program staff currently provides diabetes self-management education, diabetes prevention education, and the Walk Texas! Active Austin 10 Week Challenge (a program designed to increase physical activity through providing social support). These initiatives are provided in Travis County in community locations such as schools, churches, and worksites. These services are provided by ATCHHSD staff and trained professional subcontractors with formal academic training in nutrition or health education. Current efforts are funded through a grant from the Texas Department of State Health Services and funding from the City of Austin. Currently, these services are not provided by Promotoras or Community Health Workers (CHW's).

Community Health Workers are important to reducing barriers to chronic disease management. According to the American Diabetes Association, even with access to health care, there may be multiple individual and community barriers to adequate self-care of chronic diseases. People may lack transportation to attend regular clinic visits, have unstable work or home situations, or lack knowledge of available resources. Studies suggest that community health workers can help overcome these barriers by developing trusting, close relationships with the people they serve. Indeed, community health worker programs have improved health care access, prenatal care, pregnancy and birth outcomes, health status, and health- and screening-related behaviors among participants in the programs. Community health workers educate their peers, encourage them, and help them effectively use and navigate community and health resources. They improve the quality of life of the patients they serve and are particularly helpful in vulnerable populations, such as the elderly. There is also some evidence that community health care workers reduce health care costs. [45]

The proposed project would greatly expand ATCHHSD's ability to offer self-management education by utilizing Community Health Workers to deliver these services. This change would be transformational both in the expanded diabetes classes and the increased capacity among Community Health Workers to provide these services to the most disparate members of Austin and Travis County. Services would be expanded into churches, schools, neighborhood centers and City of Austin Parks and Recreation sites

[45] Lewin SA, Dick J, Pond P, Zwarenstein M, Aja G, Van Wyk B, Bosch-Capblanch X, Patrick M: Lay health workers in primary and community health care [Review]. Cochrane Database Syst RevCD004015 , 2005

currently not receiving diabetes self-management classes through the existing program. Currently these services are not provided and do not reach the defined target population through these described venues.

According to *The Guide to Community Preventive Services*, which is a credible resource based on a scientific systematic review process, diabetes self-management education in community settings is found to improve glycemic control among adults with type 2 diabetes. On average, published studies showed a decrease in HbA1c levels and decrease in weight among participants in these classes. Health care cost savings from improved diabetes control have been noted in published studies.[46]

Travis County has several organizations that currently work with Promotoras and CHWs such as the Promotoras de Salud/Community Health Workers of Travis County Organization, El Buen Samaritano, and Latino Health Access. This proposal would train currently certified Community Health Workers and Promotoras in diabetes education as an area of focus. Additionally, this project would recruit new Community Health Workers and provide training, specifically in the African-American Community due to pronounced health disparities in the prevalence of diabetes in Travis County. Analysis of Travis County data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that the prevalence of self-reported diabetes among adults (age 18 years and over) is 6.8% for Travis County[47]. Significant racial and ethnic disparities can be seen in the self-reported prevalence of diabetes as the prevalence among African Americans is 9.2%. The age-adjusted diabetes mortality rate in 2008 for Travis County was 12.1 deaths per 100,000 population. The mortality rates for Hispanics and African Americans were considerably higher, at 37.9 per 100,000 and 49.6 per 100,000 respectively.[48] The risk-adjusted diabetes short-term complications hospital admissions rate was 34.83 per 100,000 population in 2008 and the risk-adjusted diabetes long-term complications admissions rate was 102.16.[49] For this reason, the proposed project would focus on the African American and Hispanic communities.

Project Goals: Goal: Year 2: Increase community health workers and/or community-based organizations in the Hispanic and African-American communities that provide culturally appropriate diabetes self-management education. Issue competitive RFP to two community-based organization that support CHWs. One organization will have documented experience training and supporting CHWS working in predominately the African-American community. The other organization will be focused on training and supporting Promotoras in the Hispanic community. These organizations will provide training to CHWs on diabetes curriculum and the Department of State Health Services certified CHW training (CHWs will teach 12 series of diabetes self-management education. Each series consists of 4 classes. Each class will reach a minimum of 5 individuals. Thus, CHWs will also provide diabetes self-management education to approximately 60 individuals during year 2, providing approximately 240 health encounters.

Years 3-5: CHWs will teach 30 series of diabetes self-management education per year. Each series consists of a minimum of four classes and will be provided to a minimum of 5 individuals. Thus, CHW's will reach a minimum of 140 individuals per year with diabetes self-management education and will provide approximately 600-700 health encounters per year to these individuals.

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[46] http://www.health.state.mn.us/divs/hpsc/hep/transform/081607documents/businesscasediabetesdiseasemanagement.pdf)

[47] BRFSS 2008-2010

[48] DSHS Center for Health Statistics, Texas Health Data. Deaths of Texas Residents 2008.
http://soupfin.tdh.state.tx.us/death10.htm

[49] Texas Health Care Information Collection. Texas Hospital Inpatient Discharge Public Use Data File 2008.
http://www.dshs.state.tx.us/THCIC/Publications/Hospitals/PQIReport2008/PreventableHospitalizations2008.shtm

Improvement Goal: DSME education will demonstrate a 3 % improvement in year 4 and 5% improvement in year 5 on one or more quality of life measures among program participants collectively.

Challenges or Issues Faced by the Performing Provider

The Community Health Worker/Promotores model will provide specific outreach to these identified disparate populations. Efforts will focus on reducing barriers to disease management. Education efforts increase knowledge and empower persons with diabetes to take personal control of the disease. Several challenges may be encountered during this project. These include difficulty in recruiting participants for the diabetes self-management classes, retention of participants throughout the four classes, and issues related to the training of promotoras.

How the Project Addresses those Challenges

To address the issue of recruiting participants, we intend to draw upon strategic partnerships with Austin Independent School District (AISD) and Del Valle school district, as well as the African American Quality of Life Initiative within ATCHHSD. Schools and the faith based community are ideal locations to offer DSME classes as they are trusted within the target communities. ATCHHSD has already taught DSME classes at some elementary and middle schools in AISD and Del Valle ISD thus relationships already exist. In this proposed project, classes would be expanded to additional schools that ATCHHSD has not worked with, or additional classes would be offered at current schools or faith based organizations to meet the demand for services. To retain participants, it is important for the facilitator of the classes to connect on a one-on-one basis with the participants. With trained CHWs facilitating the classes, participants will be able to relate to one of their peers who understand the everyday challenges of life with diabetes as well as the socioeconomic stresses and other life circumstances that play into an individual's ability to manage a chronic disease well. Finally, the issue of training of CHWs is imperative in order for the DSME classes to be successful. For this reason, ATCHHSD will contract to provide comprehensive training on the DSME curriculum, which will be a requirement of all CHWs who have not received this training to attend.

How the Project is Related to RHP Goals

This project addresses increasing capacity of the local infrastructure through CHW's to provide DSME classes and increasing availability of DSME classes for populations experiencing higher rates of diabetes. The proposed DSME community based approach has been shown to improve quality of life and is a predictor of improved diabetes compliance and health outcomes. Additionally, DSME education will increase the number of people with health lifestyles and would improve overall population health. As a result this project is related to the RHP goals:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations
5. Support prevention education and healthy lifestyles to improve population health

Starting Point/Baseline

Baseline Data

Currently, 0 CHWs or promotoras are recruited and trained.
Currently, 6 DSME classes provided per year.

Time Period for Baseline

The time period for this baseline was Fiscal Year 2011-2012

Rationale

Reason for Selection of Project Options and Components
ATCHHSD selected project option 2.6.2 Establish self-management programs and wellness using evidence-based designs. This proposed project would utilize one or more of the three evidence-based curricula for diabetes self-management education designed for implementation by CHWs. These include the Diabetes Education Empowerment Program (DEEP), Do Well Be Well with Diabetes (created by Texas AgriLIFE extension), or the Stanford Chronic Disease Self-Management curriculum. These curriculum are all between 6 and 8 modules in length although longer curriculum can be condensed (ATCHHSD currently teaches DEEP by combining the 8 modules into 4 sessions). Do Well Be Well with Diabetes and DEEP cover similar topics such as diabetes symptoms, medications, self-monitoring, nutrition, physical activity, support systems, and working with your health care provider. The Stanford Chronic Disease Self-Management program takes a different approach, stressing psychosocial aspects of managing a chronic disease. All have been proven to have a positive impact on participant's attitudes and behaviors, and health outcomes. ATCHHSD will identify the most appropriate curriculum and approaches for the target populations proposed by this project.

As a result, the project will focus on improving quality of life through assessments that are validated for persons with diabetes. DSME has been shown to improve quality of life and is a predictor of improved diabetes compliance and health outcomes.

Reason for Selection of Milestones & Metrics
P-3 Milestone: Implement, document and test an evidence-based innovative project for target population was selected to document strategy and testing outcomes of diabetes evidence-based self-management program for African American and Hispanic with diabetes.

P-4 Milestone: Execution of a learning diffusion strategy for testing, spread and sustainability of best practices and lessons learned was selected to document lessons learned and diffusion of project plans and actions to communication best practices to key community stakeholders.

P-5 Milestone: Execution of an evaluation process for project innovation was selected to document the evaluation process, tools and analytics for implementation of the evidence-based self-management program. Items to evaluate will be process measures including outreach and class promotion, class enrollment including class demographics, pre and post-test of participant knowledge, and class retention rates.

I-8 Milestone: Increase access to health promotion programs and activities using innovative project option was selected to measure the efficacy of the diabetes self-management program in reaching the target population (African Americans and Hispanics with diabetes.)

Unique Community Need Identification Number-
CN.9 – High rates of chronic disease such as cardiovascular disease, cancer, and rising rates of diabetes, CN17 – Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative
This proposed project will more than triple the current level of services for diabetes self-management education. It is transformational in that it will result in the training of CHWs on evidence based curricula

that will reach African Americans and Hispanics with diabetes through a new evidence based approach tailored for these groups.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS): N/A

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected: OD -10 Quality of Life/Functional Status

Reasons/Rationale for Selecting the Outcome Measure(s)

OD-10: Quality of Life/Functional Status

IT-10.1 Quality of life-Disease management and maintaining good diabetes control is directly related to a person's quality of life and is a predictor of improved health outcomes. [50] Additionally, disease management and self-care training has been shown to improve quality of life. [51]

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The City of Austin HHSD proposed project will offer community based education for patients transitioning from intense outpatient programs to assist with on-going disease maintenance. Additionally, the proposed, diabetes DSME program will have a focus on promoting immunizations including the annual flu vaccine. Class participants will also be provided linkages to vaccine clinics to reduce barriers to receiving vaccines.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

201320302.2.1 – ACT for Permanent Supportive Housing

201320302.2.6 – Adult Immunizations

List of Related Category 4 Projects *(RHP Project ID Number) N/A*

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

This program focuses on a similar target population as the Family and Child Obesity project (186599001.2.1). This project will support the two proposed projects below. Other projects that also focus on diabetes include the Hays County Mental Health Center Integrated Care: Similar diagnosis (133340307.2.1), and Expanding Access to Specialty Care: Similar diagnosis (176692501.1.1). Other related projects include:

133542405.2.6 - Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services

133340307.2.9 - Recruit, train and support consumers of mental health services to provide peer support services Adult Whole Health Peer Support

307459301.2.1 - The Community Care Collaborative's Patient-Centered Medical Home

[50] http://journal.diabetes.org/diabetesspectrum/00v13n1/pg21.htm

[51] http://www.ncbi.nlm.nih.gov/pubmed/18832286

307459301.1.1 - The Community Care Collaborative's Implementation and enhancement of chronic disease management registry functionalities

307459301.2.2 - Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions

137265806.2.9 - Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives - smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach for Valuing Project

The project valuation is based on estimated impact of DSME classes provided by CHWs on health care costs. ATCHHSD estimates that the value of the service is double that of every dollar spent.

Rationale/Justification for Valuation

Services provided by CHW's have been shown to reduce health care costs yielding at least a 2 dollar savings for every dollar spent.[52] Additionally, a study by Brown et al found that a lifestyle modification program led by community health workers for low income Hispanic adults with type 2 diabetes had an incremental cost effectiveness ratio that ranged from $10,995 to $33,319 per quality of life years gained when compared to usual care.[53]

Additionally, according to JAMA, studies have demonstrated that a 1% reduction in HbA1c suggests health care cost savings of approximately $400 to $4000 per patient over the ensuing 3 years, with the savings increasing with the level of baseline HbA1c and the presence of vascular diseases. This project has the potential to reduce $1,600,000 per year in health care costs.

[52] http://www.ncbi.nlm.nih.gov/pubmed/16520499

[53] http://www.cdc.gov/pcd/issues/2012/12_0074.htm

201320302.2.2	***2.6.2***	***2.6.2***	***EXPANSION OF COMMUNITY DIABETES PROJECT***	
City of Austin Health and Human Services				201320302.2.2
Related Category 3 Outcome Measure(s):	201320302.3.2	*OD-10.1*	*Quality of Life/Functional Status* *Quality of Life*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-3 Milestone: Implement, document and test an evidence-based innovative project for target population. Specific activities include: • Identify and recruit Community Health Workers and/or community based organizations in the Hispanic and African American Community to provide culturally appropriate diabetes self management education • Conduct Training for Community Health Workers on diabetes curriculum and the Department of State Health Services Certified CHW training Metric 1 P-3.1 Document implementation strategy and testing outcomes Baseline/Goal: Implement new and expanded evidence-based diabetes	**Milestone 2** P-3 Milestone: Implement, document and test an evidence-based innovative project for target population. Specific activities include; • Conduct Diabetes Self - Management Education for 140 persons with diabetes Metric 2: P-3.1 Document implementation strategy and testing outcomes Baseline/Goal: Maintain new and expanded evidence-based diabetes self-management curriculum targeting African Americans and Hispanics. Data Source: Performing Provider program data Milestone 2 Payment *(maximum amount):* $270,000 **Milestone 3**: P-5 Execution of an evaluation process for project innovation. Specific activities will be to implement a process		**Milestone 4** P-3 Milestone: Implement, document and test an evidence-based innovative project for target population. Specific activities include • Conduct Diabetes Self - Management Education for 140 persons with diabetes Metric 4: P-3.1 Document implementation strategy and testing outcomes Baseline/Goal: Maintain new and expanded evidence-based diabetes self-management curriculum targeting African Americans and Hispanics. Data Source: Performing Provider program data Milestone 4 Payment *(maximum amount):* $270,000 **Milestone 5** P-4 Milestone: Execution of a learning diffusion strategy for testing, spread and	**Milestone 6** P-3 Milestone: Implement, document and test an evidence-based innovative project for target population. Specific activities include: • Conduct Diabetes Self - Management Education for 140 persons with diabetes Metric 6: P-3.1 Document implementation strategy and testing outcomes Baseline/Goal: Maintain new and expanded evidence-based diabetes self-management curriculum targeting African Americans and Hispanics. Data Source: Performing Provider program data Milestone 6 Payment *(maximum amount):* $240,000 **Milestone 7:** I-8 Increase access to health promotion programs and activities using innovative project option. Milestone will increase the

201320302.2.2	***2.6.2***	***2.6.2***	***EXPANSION OF COMMUNITY DIABETES PROJECT***	
City of Austin Health and Human Services				201320302.2.2
Related Category 3 Outcome Measure(s):	201320302.3.2	*OD-10.1*	*Quality of Life/Functional Status* *Quality of Life*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
self-management curriculum targeting African Americans and Hispanics reaching 60 individuals. Data Source: Performing Provider program data Milestone 1 Payment *(maximum amount):* $190,000	evaluation plan measuring: • outreach and class promotion • class enrollment including class demographics • pre and post-test of participant knowledge • class retention rates <u>Metric 3: P-5.1</u> Document the evaluation process, tools and analytics. Baseline/Goal: Implement process evaluation Data Source: Performing Provider program data Milestone 3 Payment *(maximum amount):* $270,000		sustainability of best practices and lessons learned. Milestone will: Communicate lessons learned and project best practices through meetings with key community stakeholders Metric 5: P-4.1 Document implementation of communication strategy Baseline/Goal: Implement communication strategy Data Source: Performing Provider program data Milestone 5 Payment (maximum amount): 270,000	number of African Americans and Hispanics with Diabetes accessing diabetes self-management classes Metric 7 I-8.Increase percentage of target population reached. Numerator: Number of persons reached through Diabetes Self-Management Classes from target population (African Americans and Hispanics with Diabetes.) Estimated reach is 480 persons Denominator: Number of African Americans and Hispanics with diabetes in Travis County Data Source: Performing Provider Program data Milestone 7 Payment (maximum amount): 240,000
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments*	Year 3 Estimated Milestone Bundle Amount: $540,000		Year 4 Estimated Milestone Bundle Amount: $540,000	Year 5 Estimated Milestone Bundle Amount: $480,000

201320302.2.2	***2.6.2***	***2.6.2***	***EXPANSION OF COMMUNITY DIABETES PROJECT***	
City of Austin Health and Human Services				201320302.2.2
Related Category 3 Outcome Measure(s):	201320302.3.2	*OD-10.1*	*Quality of Life/Functional Status* *Quality of Life*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	
amounts from each milestone): $190,000				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,750,000				

City of Austin Health and Human Services
Tobacco Prevention and Cessation Program for 18-24 years olds in Travis County
201320302.2.3 Pass 1

Provider: City of Austin Health and Human Services Department is the local health authority that has public health jurisdiction over Austin/Travis County with a population of 1,024,266 residents. The Department has two immunization clinics, one refugee clinic and one STD clinic. In addition, the Department provides preventive health services, programming and education; policy, systems, and environmental health recommendations; emergency preparedness and response; neighborhood center operations and contracting for social services with community agencies.

Intervention(s): This project is an evidence-based comprehensive tobacco prevention and cessation intervention to reduce tobacco use among the 18-24 year old population. The specific activities proposed to reach this population will:
Expand tobacco-free policies in new settings frequented by 18-24 year olds.

Integrate a tobacco use assessment and cessation referral tool into social service agencies and health care organizations utilized by 18-24 year olds.

Implement a new media campaign focused on tobacco prevention and promotion of cessation services targeting 18-24 year olds

Need for the project: Tobacco use is the most prevalent cause of premature death in Travis County, accounting for more than 570 lost lives in 2008--more than alcohol, auto accidents, AIDS, drugs, suicides, homicides and fires combined. In Travis County, 14% of adults currently smoke and 20% use some type of tobacco product. Significant disparities in smoking rates exist among resistant, hard-to-reach, medically indigent populations and 18-24 year olds in our community. In Travis County 34 % of young adults age 18-24 are living in poverty compared to the overall poverty rate of 15%.[54] Additionally, young adults 18-24 years old have the highest prevalence of smoking of any age group, at 24%. More than 80% of adult smokers begin smoking by 18 years of age with 99% of first use by 26 years of age. Smoking rates among Travis County residents making less than $25,000 per year is 23.6% and smoking rates among Travis County adults with no health insurance is 25.8% compared to the overall smoking rate of 14% among Travis County adults. Addressing young adult smoking is important because cessation before age 30 avoids almost all the long-term effects of smoking.

Target population: The target population for this intervention is 18-24 year olds with targeted focus on the 34% of 18-24 year olds living in poverty/indigent. This project will be able to measure the number of Medicaid eligible persons accessing tobacco cessation services.

Category 1 or 2 expected patient benefits: The project seeks to increase the number of 18-24 year olds accessing tobacco cessation services by 50%.
Category 3 outcomes: ***IT-12.6 Other Outcomes Improvement Target*** - Adult Current Smoking Prevalence: This project goal is to reduce tobacco use among the 18-24 year old population in Travis County by 5%.

[54]http://www.co.travis.tx.us/health_human_services/research_planning/publications/acs/acs_focus_on_poverty_2011.pdf

Title of Project: **Tobacco Prevention and Cessation Program for 18-24 years olds in Travis County**

Project Option: **2.7.2 Implement Evidenced Based Disease Prevention Programs to reduce tobacco use**

RHP Project Identification Number: **201320302.2.3 Pass 1**

Performing Provider Name: **City of Austin Health and Human Services Department**

Performing Provider TPI/TIN: **201320302**

Project Description

Overall Project Description: The Austin/Travis County Health and Human Services Department (ATCHHSD) proposes a five-year tobacco prevention and cessation project that will expand on its existing activities and implement new interventions to prevent initiation of tobacco and reduce the prevalence of tobacco use among 18-24 year olds.

This project is a comprehensive intervention that requires an evidenced-based multi-pronged approach to reduce tobacco use among the 18-24 year old population. The specific activities proposed to reach this population will:

- Expand tobacco-free policies in new settings frequented by 18-24 year olds.
- Integrate a tobacco use assessment and cessation referral tool into social service agencies and health care organizations utilized by 18-24 year olds.
- Implement a new media campaign focused on tobacco prevention and promotion of cessation services targeting 18-24 year olds.

ATCHHSD's current tobacco prevention and control activities focus on the general population and on implementation of community tobacco-free policy, systems and environmental changes. The proposed project will **expand** current policy efforts by implementing tobacco-free policies in **new** settings that are frequented by young adults including institutions of higher learning including colleges, universities, trade and technical schools; multi-unit housing, select worksites and entertainment venues. Tobacco-free policies prevent tobacco use by changing social norms about smoking and reduce tobacco use by reducing the opportunities to smoke. Tobacco-free policies prohibit the use of tobacco on the entire facility property, both indoors and outdoors. Free cessation services will accompany all policy implementation plans to establish supportive environments that promote reduced tobacco use and cessation for potential quitters. Referrals will focus on the Texas Quitline and the Seton Cessation Resource Center.

ATCHHSD will develop and implement **two new** interventions for this proposal. The first is the integration of a tobacco-use assessment and cessation referral tool into existing operations and electronic medical records of social services and health care organizations that provide services to 18-24 year olds of low socioeconomic status, victims of violence/abuse or neglect and other at-risk populations. Referrals will focus on the Texas Quitline and the Seton Cessation Resource Center. These organizations will be identified through an existing partnership with One Voice Central Texas which is a network of community-based health and human service organizations representing a broad spectrum of critical and essential services in our community. ATCHHSD will provide specific outreach and technical assistance to identified organizations to implement these systems changes.

The second **new** intervention is a mass media campaign to promote the Texas Quitline. The educational and communication campaign will be a mix of traditional and innovative media and grassroots marketing strategies that will complement the other strategies to increase calls to the Quitline, increase cessation and reduce the prevalence of tobacco use among the target 18-24 year old age group.

The proposed project will target 18-24 year olds in Travis County because this age group has the highest prevalence of smoking (25%) among all age groups in the County. The proposed project will be implemented by the ATCHHSD, which has public health jurisdiction over the entire county of 1,024,266 residents.

Project Goals:

1. Reduce tobacco use among the 18-24 year old population in Travis County by 5% in five years.

Challenges or Issues Faced by the Performing Provider

Significant challenges exist when implementing interventions for the 18-24 year-old target population, including the diversity of people in the age group, their susceptibility to industry marketing tactics, and the limitations of policy-focused interventions.

Young adults in Travis County comprise a wide variety of individuals and include people from low-income or low-educational backgrounds, college and vocational students, those with behavioral or substance abuse problems, those transitioning from foster care or homelessness into permanent housing or the workforce, and those dealing with the justice system. Young adults are especially susceptible to social and environmental influences and the tobacco industry targets young adults to market their products to them, with an emphasis on vulnerable subpopulations such as racial, ethnic and sexual minorities. In addition, although many tobacco-free policies have been implemented in Austin and Travis County and the proposed tobacco-free policies will increase the number in more environments frequented by the target populations, many venues will still exist for young adults to use tobacco. In addition, young adults are switching to smokeless tobacco products due to these increases in non-smoking environments.

How the Project Addresses those Challenges

The proposed project will focus interventions on the diverse places where young people gather, including non-traditional environments. For example, the tobacco assessment and referral tool will be integrated in social service agencies to reach the most vulnerable young adults; tobacco-free school policies will focus on those attending school, and guerilla marketing tactics, which are unconventional marketing efforts tailored to promote messages to a specific population, will target those young adults who eschew traditional environments. In addition, mass media campaign will target a variety of outlets that are accessed by the different 18-24 year old subgroups with new media messaging**.**

How the Project is Related to RHP Goals

This project will reduce tobacco use through implementation of tobacco-free campus policies, implementation of a tobacco use assessment and referral tool in social services agencies and health care organizations, and promotion of tobacco prevention and cessation services through mass media. These efforts should have a significant effect on the smoking status of the target population and support the following RHP goals:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. This project supports this goal through the integration of a tobacco use assessment and screening tool into electronic medical records and social service client systems.
5. Support prevention education and healthy lifestyles to improve population health.

Starting Point/Baseline

Baseline Data

1. 13 persons 18-24 years old in Travis County call the Texas Quitline per year
2. 24.5% prevalence of smoking among 18-24 year-old population in Travis County

Time Period for Baseline

The time period for this baseline is 2011

Rationale

Reason for Selection of Project Options and Components

ATCHHSD selected project option 2.7.2 Implement innovative evidence-based strategies to reduce tobacco use in order to establish evidence-based disease and disability prevention programs for targeted population to reduce their risk of disease, injury, and disability. This project will reduce tobacco use among the 18-24 year old population through evidence-based strategies.

Reason for Selection of Milestones & Metrics

"P-1 Milestone: Development of innovative evidence-based project for targeted population" and "P-2 Milestone: Implement evidence-based innovational project for target populations," were selected to identify, develop and test a new model of comprehensive tobacco control for the 18-24 year old population that will lead to a new system that delivers better health, better care and reduces costs.

"P-4 Milestone: Execution of evaluation process for project innovation" was selected to systematically identify method to improve and account for public health tobacco control efforts for the 18-24 year old population by involving procedures that are useful, feasible, ethical, and accurate.

"P.X Milestone: Customizable Process Milestone" was selected to establish baseline rates for number of persons 18-24 that access cessation services.

"1-5 Milestone: Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model" was selected to test innovative intervention model variables for the 18-24 year old population to access evidence-based cessation services that will have an impact on better health improved care and lower costs.

Community Need

Tobacco use is the most prevalent cause of premature death in Travis County (CN.12), accounting for more than 570 lost lives in 2008--more than alcohol, auto accidents, AIDS, drugs, suicides, homicides and fires combined. In Travis County, 14% of adults currently smoke and 20% use some type of tobacco product. Significant disparities in smoking rates exist among resistant, hard-to-reach, medically indigent populations and 18-24 year olds in our community. In Travis County 34 % of young adults age 18-24 are living in poverty compared to the overall poverty rate of 15%.[55] Additionally, young adults 18-24 years old have the highest prevalence of smoking of any age group, at 24%. More than 80% of adult smokers begin smoking by 18 years of age with 99% of first use by 26 years of age. Smoking rates among Travis County residents making less than $25,000 per year is 23.6% and smoking rates among Travis County adults with no health insurance is 25.8% compared to the overall smoking rate of 14% among Travis County adults. Addressing young adult smoking is important because cessation before age 30 avoids almost all the long-term effects of smoking.

[55]http://www.co.travis.tx.us/health_human_services/research_planning/publications/acs/acs_focus_on_poverty_2011.pdf

ATCHHSD selected the target age group of 18-24 year olds for this proposal because more than 80% of adult smokers begin smoking by 18 years of age with 99% of first use by 26 years of age. Addressing young adult smoking is important because cessation before age 30 avoids almost all the long-term effects of smoking.

ATCHHSD selected the Texas Quitline calls as an outcome measure because the Quitline has demonstrated success increasing cessation among young adults. The U.S. Public Health Service's recently updated clinical practice guidelines found that Quitline counseling can more than double a smoker's chances of quitting. Quitline counseling combined with medication (such as nicotine replacement therapy) can more than triple the chances of quitting.[56]

Unique Community Need Identification Number-
CN.9 – High rates of chronic disease such as cardiovascular disease, cancer, and rising rates of diabetes
CN.18 – Tobacco use remains a leading cause of preventable death

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative
Current ATCHHSD tobacco prevention and cessation efforts have focused on the general population and this proposal offers the opportunity to implement innovative strategies to young adults 18-24 years old.

ATCHHSD's project proposal will **expand** on its existing activities in new settings and implement **two new** interventions in Travis County. Currently, ATCHHSD provides technical assistance to workplaces to help them adopt tobacco-free or smoke-free policies on their grounds. This proposed project will allow ATCHHSD staff to provide technical assistance to new environments frequented by young adults, to help them adopt tobacco-free policies. These new venues include institutions of higher learning including colleges, universities, trade and technical schools; multi-unit housing, and entertainment venues.

ATCHHSD will also implement two new interventions in its proposal, including a mass media campaign that will appeal to young adults 18-24 and the integration of a tobacco-use assessment and cessation referral tool in social service and other environments that will promote use of the Texas Quitline.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
SAMSHA Funding Substance Abuse Prevention and Treatment Block Grant provides substance abuse treatment and prevention dollars to Texas which is then distributed to local substance abuse treatment and prevention providers including Austin Travis County Integral Care, the local mental health and substance abuse authority. This includes requirements for prevention of youth access and enforcement and substance abuse prevention including tobacco and other gateway drugs.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected:

OD-12 Primary Care and Primary Prevention

[56] Fiore, MC, et al., *Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline*, U.S. Public Health Service, May 2008, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.

IT-12.6 Other Outcome Improvement Target: Adult Current Smoking Prevalence. The selected outcome improvement target was endorsed by National Quality Forum as a Cancer Population Health Measure on October 24, 2012.[57]

This indicator has also been identified nationally by the Health and Human Services Health Indicators Warehouse and Healthy People 2020.[58,59]

Reasons/Rationale for Selecting the Outcome Measure(s)

1. This project proposes a tobacco cessation program funded at $3 per person. Studies have shown this to be effective in reducing smoking. As a result, long-term savings will be achieved.[60]
2. Implementing evidence-based strategies to reduce smoking among the 18-24 year old population will reduce the leading cause of preventable death in Travis County.[61]

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The City of Austin Health and Human Services Department is only proposing one project related to this topic area and to this population.

List of Related Category 1 & 2 Projects *(RHP Project ID Number): NA*

List of Related Category 4 Projects *(RHP Project ID Number): NA*

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

This proposed project will increase access to tobacco cessation for populations with the highest prevalence of tobacco use, young adults 18-24 years old. Efforts will be coordinated to assist with tobacco education and referrals to tobacco cessation programs. This project's focus on young adults overlaps with the School Campus Counseling (186599001.1.1) which also focuses on young adults in Travis County. Bluebonnet Trails Community Services (126844305.1.3) and Hill Country MHDD Centers (133340307.2.10) are proposing similar projects for youth in other counties throughout Region 7.

This project is similar to the Integrate Whole Health Peer Support project (133542405.2.6) by Austin Travis County Integral Care (ATCIC) due to its focus on prevention and wellness. The target populations that ATCHHSD will reach through this proposal include behavioral health clients. ATCHHSD's

[57] http://www.beckershospitalreview.com/quality/nqf-endorses-cancer-population-health-measures.html

[58] http://www.healthindicators.gov/Indicators/Cigarettesmoking-Adults(aged18yearsandover)_1498/Profile/Data

[59] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=41

[60] Settlement-Funded Tobacco Control in Texas: 2000- 2004 Pilot Project Effects on Cigarette Smoking. Public Health Reports. 2006 May- June; 121, 235-238.

[61] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=41

community-based efforts will be coordinated with and complement ATCIC's proposed behavioral health interventions regarding tobacco use. ATCIC is a long-term partner of ATCHHSD.

Through reduced tobacco use, this project will also benefit the Community Care Collaborative's project to Expand Specialty Care Capacity for Pulmonology (307459301.1.7).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives - smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach for Valuing Project

The project valuation is based on the number of 18-24 year old persons that call the Texas Quitline or other cessation services which is a conservative estimate considering that we know many others will quit but may not utilize the Quitline as a result of this intervention. ATCHHSD estimates a value of $3,388 per person utilizing cessation services. ATCHHSD estimates that each demonstration year 150 persons (reaching 600 persons over the total project period) who are 18-24 year will access tobacco cessation services, which has the potential to produce a savings of $508,200 annually. The intervention will have an impact on the overall community and will increase quitline callers from the general population by 50 (reaching 400 persons over the total project period) persons which has the potential to produce an additional savings of $169,400 per year. Total reach for this project is 800 person over the project period.

Rationale/Justification for Valuation

According to the CDC, cigarette smoking costs more than $193 billion (i.e., $97 billion in lost productivity plus $96 billion in health care expenditures). Secondhand smoke costs more than $10 billion (i.e., health care expenditures, morbidity, and mortality). This project proposes a tobacco program funded at $3 per person. Studies have shown this to be effective in reducing smoking. As a result, long term savings will be achieved.[62] According to the Estimated Smoking-Attributable Mortality and Economic Costs in Austin for 2007, costs of smoking due to loss of productivity ($1372 per person) and personal health care costs ($2016 per person) total $3,388 per person who smokes. Our estimated valuation of $677,600, as noted above, is conservative as we anticipate that implementation of the project proposal will result in an overall

[62] Settlement-Funded Tobacco Control in Texas: 2000- 2004 Pilot Project Effects on Cigarette Smoking. Public Health Reports. 2006 May-June;121, 235-238.

5% reduction in smoking among the estimated 31,878 18-24 year old smokers which over 5 years would lead to a $3,388,000 estimated reduction in health care costs and lost productivity.

The U.S. Public Health Service's recently updated clinical practice guidelines found that quitline counseling can more than double a smoker's chances of quitting. Quitline counseling combined with medication (such as nicotine replacement therapy) can more than triple the chances of quitting.[63]

[63] Fiore, MC, et al., *Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline*, U.S. Public Health Service, May 2008, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.

201320302*.2.3*	***2.7.2***	***2.7.2***	Tobacco Prevention and Cessation Program for 18-24 years olds in Travis County	
City of Austin Health and Human Services				201320302
Related Category 3 Outcome Measure(s):	201320302***.3.3***	*OD.12.6*	Primary Care and Primary Prevention Other Outcome Improvement Target: Smoking Prevalence Among 18-24 year olds in Travis County	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Development of smoking cessation and prevention program for adults age 18-24 in Travis County that includes: • media campaign • technical assistance through partnerships to worksites, schools, etc. to implement tobacco-free campus • technical assistance to social services and health care organizations to increase inclusion of tobacco-use assessment and cessation referral clinical protocols into existing operations Metric 1 P-1.1 Document development of programs and plans Baseline/Goal: Completion of program planning for establishing new project targeting 18-24 year-olds that promotes the Quitline Data Source: Report including program documentation and implementation plan	**Milestone 3:** P-2 Milestone: Implement smoking cessation and prevention program for adults age 18-24 in Travis County that includes: • mass media strategy • Activities for increasing tobacco-free worksites, schools, etc. • Service and health care organizations adopt tobacco-use assessment and cessation referral clinical protocols into existing operations Metric 3 P-2.1 Document program implementation plan Baseline/Goal: Completion of implementation of program. Data Source: Performing Provider program data and documents confirming implementation **Milestone 3 Payment *(maximum***		**Milestone 4:** P-4 Milestone: Execution of evaluation process for project. Metric4: P-4.1 Document evaluation plan and implementation process. Goal: Implement project evaluation plan Data Source: Performing provider program data. **Milestone 4 Estimated Incentive Payment: $630,000**	**Milestone 5:** 1-5 Milestone: l Increase number of 18-24 year olds accessing cessation services over the project implementation period by 150 per year with a total reach of 800 over the project period. Metric5: I-5.1 Percent of 18-24 year olds accessing tobacco cessation services Goal: Increase by 50 % the number of 18-24 year olds accessing tobacco cessation services Data Source: Texas Quitline and Seton Cessation Resource Center **Milestone5 Estimated Incentive Payment: $ 560,000**

201320302*.2.3*	***2.7.2***	***2.7.2***	Tobacco Prevention and Cessation Program for 18-24 years olds in Travis County	
City of Austin Health and Human Services				201320302
Related Category 3 Outcome Measure(s):	201320302***.3.3***	*OD.12.6*	Primary Care and Primary Prevention Other Outcome Improvement Target: Smoking Prevalence Among 18-24 year olds in Travis County	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Payment *(maximum amount):* $285,000 **Milestone 2:** Customizable Process Milestone P.X: Establish baseline rates for number of persons 18-24 that access cessation services. Metric 2 P-X.1 Document data collection methods Baseline/Goal: Collect baseline data to document number of persons 18-24 Data Source Report including program documentation **Milestone 2 Payment *(maximum amount):* $285,000**	***amount):* $630,000**			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $570,000	Year 3 Estimated Milestone Bundle Amount: $630,000		Year 4 Estimated Milestone Bundle Amount: $630,000	Year 5 Estimated Milestone Bundle Amount: $560,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,390,000				

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City of Austin Health and Human Services Department (HHSD)

PRENATAL, POSTNATAL PROGRAM

RHP Project Identification Number: 201320302.2.4 Pass 2

Provider: City of Austin Health and Human Services Department is the local health authority that has public health jurisdiction over Austin/Travis County with a population of 1,024,266 residents. The Department has two immunization clinics, one refugee clinic and one STD clinic. In addition, the Department provides preventive health services, programming and education; policy, systems, and environmental health recommendations; emergency preparedness and response; neighborhood center operations and contracting for social services with community agencies.

Intervention(s): The Prenatal & Postnatal Program will use Community Health Workers (CHWs) to improve birth and twelve-month postnatal outcomes with an emphasis on African American women in the community through increased access to pre- and post-natal care and health literacy.

Need for the project: In Travis County, White women are twice as likely to receive prenatal care as African American women, and three times to receive prenatal care as Hispanic women. Further, African American births are three times as likely to be of low weight as other groups', and infant mortality rates for African Americans are more than twice that of other groups, at 11.5 per 100 compared to 5.4 for all groups. (Texas Department of State Health Services, 2009 data).

Target population: The target population will be low-income African American and Hispanic families that are expecting or planning a pregnancy. It is anticipated that a majority of the families will be Medicaid eligible and/or uninsured. Outreach will be coordinated with multiple community partners with a focus to recruit African-American families.

Category 1 or 2 expected patient benefits: The Project estimates that 100 patients will be served in Year 4 and 150 in Year 5.

Category 3 outcomes: IT-8.2 Percentage of low birth-weight births: The goal is to reduce the cohort's low birth-weight percentage by at least 5% by Year 4 and 10% by Year 5 from the baseline established in Year 2. This will impact the all-births rate by a percentage TBD.

Title of Project: **PRENATAL, POSTNATAL PROGRAM**

Category / Project Area / Project Option: **2.6.3 Engage community health workers in an evidence based program to increase health literacy of a targeted population**

RHP Project Identification Number: **201320302.2.4 Pass 2**

Performing Provider Name: **City of Austin Health and Human Services Department (HHSD)**

Performing Provider TPI: **201320302**

Project Description

Overall Project Description

The **Community Health Worker (CHW) Prenatal & Postnatal Program** using Community Health Workers (CHW) will improve birth and postnatal outcomes within the African American \and other low income uninsured communities by facilitating access to pre- and post-natal care throughout a woman's pregnancy. CHWs will provide outreach, education, recruitment, referral and navigation services to women who are at risk for poor birth outcomes, particularly low-birth weight and infant mortality. The proposed program will target specific communities with high rates of infant mortality, late or no prenatal care, teen pregnancies and births, and births to low-income and uninsured women. The program's focus is on getting pregnant women into early and consistent prenatal care and ensuring their families receive primary and preventive health care services, while emphasizing self-care through enhanced health literacy.

The City of Austin recognizes a gap in outreach and services for the targeted population regarding comprehensive prenatal and preconception care. The City of Austin's *2012 Critical Health Indicators Report* identified birth disparities as significant for African-American families. These families may not receive early and adequate prenatal services, nor the follow-up post-natal care needed to provide "a safe birth, healthy childhood".

Services will be provided by CHWs who live in or are familiar with the African American and other low income uninsured communities. The Prenatal & Postnatal Program will work with CHWs to implement a comprehensive patient navigation system that provides outreach, education, recruitment, referral, and navigation services to at-risk pregnant women. Each family will present a unique set of risk factors that may include low-income, lack of a connection to medical services, teen pregnancy, isolation/lack of a support system, and maternal health issues such as obesity, substance abuse, smoking and mental health issues. Navigation services will include: follow-up, case management, advocacy and home visiting services, along with educational programming to promote healthy behaviors and self-care. Overall, the CHWs will provide a community-based system of care and social support that will improve access to pre- and post- natal care throughout a woman's pregnancy and work with her for a year post-birth.

This program will utilize CHWs, also known as lay health educators, community health representatives, peer health promoters, community health outreach workers, and promotores de salud , because they promote health among communities that have traditionally lacked access to health and social services. CHWs create a bridge between providers of health services and social and community services to the underserved and hard to reach communities. CHWs live in the communities in which they work, understand what is meaningful to their communities, communicate in the language of their community, and recognize and incorporate cultural buffers (e.g., cultural identity, spiritual coping, traditional health

practices) to help community members and promote health outcomes. This connection to the community enhances a CHWs ability to interpret the health care system and provide enrollees the skills needed to navigate the system on their own.

CHWs strengthen existing community networks by building partnerships with formal health and human services systems to connect people with the services they need and to stimulate social action that influences community participation in the health system. Using their unique position, skills, and an expanded knowledge base, CHWs can help improve outcomes for community members.

Improving engagement will be essential; the program will be open to diverse/multiple prenatal care methods that may prove to be more effective for some clients. One such method may be group sessions similar to the "Centering Pregnancy" design where a small cohort of women with closely grouped delivery due dates meet in a facilitated group about 10 times from mid-term into post-partum (www.centeringhealthcare.org). The social support aspect and stable composition of the group may help keep socially isolated women returning for follow-up visits.

Outreach methods to community and service providers are critical to identify and recruit women in order to make connections to services. Planning effective outreach will be as important as designing effective services. The proposed program will provide coordinated outreach, consultation, and follow-up with community service providers to connect women at preconception and during pregnancy with a medical home and with postnatal services for the child and parents.

Additionally, the CHWs will:

- Facilitate access to and utilization of prenatal care, specifically the timing of the first prenatal visit to be in the first trimester by conducting intensive outreach efforts to pregnant women, including pregnant women who are uninsured, underinsured, are not involved in prenatal, health or other community services, and other high risk populations living in the target area .
- Provide available support systems and knowledge of and connection to community resources during the prenatal, perinatal, and infancy periods.
- Develop and maintain a relationship with the family during home visits, which are made at least monthly throughout the woman's pregnancy and throughout the infant's first year of life.
- Provide basic health education to families on a range of health topics breastfeeding, family planning, risk factors associated with prenatal substance abuse (including tobacco), domestic violence, and other important health topics.
- Assist families with application procedures for such services as Medicaid, WIC and other relevant services to include assisting families to identify a medical home and pediatric care.
- Work with parents to ensure children receive immunizations and regular health care.
- Help families address such issues as selecting appropriate childcare and handling the multiple demands of child rearing. This will include assisting families to access parent education during pregnancy and infancy.
- Work with parents in their homes to improve parent-child interaction and to promote their understanding of normal child development.
- Assist families to develop the necessary skills and resources to improve their health status, family functioning and self-sufficiency.

- The proposed system will provide coordinated outreach, consultation, and follow-up to connect women at preconception and during pregnancy with a medical home and with postnatal services for the child and parents.

HHSD, collaborators, and contractors will address challenges from three perspectives: community leadership, health and social services providers, and families.

Project Goals

The Prenatal & Postnatal Program proposes the following outcome goals:

- Reduce the incidence of low and very low birth weights.
- Reduce preterm births.
- Reduce the infant mortality rate.

Challenges or Issues Faced by the Performing Provider

A challenge will be to engage and build trust with the targeted communities. Despite several efforts to create access and awareness regarding the importance of access to care, African American and Hispanic women continue to have substantially worse access to prenatal care.

A further barrier to the program's implementation and operation is the limited number of Certified CHWs in Travis County.

How the Project Addresses those Challenges

CHWs have been shown to engage and build trust with hard-to-reach communities. This project's CHWs will use innovative and culturally relevant methods to gain inroads to the identified communities, such as linking with traditionally African American churches, historically black institutions of higher education, and others.

Multiple outreach, engagement, and delivery modalities will be used to be responsive to women and their families. Referrals of women in early pregnancy or even preconception will be achieved by using multiple sources, with some being non-traditional, such as faith communities, neighborhood associations, apartment managers, child care centers, schools, workplaces, and media campaigns, including the use of social media.

In Texas, the Department of State Health Services has implemented a certification for Community Health Workers. This DSRIP project will work with that credentialing program to recruit, train, place and retain skilled CHWs.

How the Project is Related to RHP Goals

Regional Goal #2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Through establishing a medical home and encouraging early prenatal exams the Project will reduce health care costs for the participating families.

Regional Goal # 5. Support prevention education and healthy lifestyles to improve population health.

The case management and education done by Promotoras will assist parents in making healthy choices for their child and family, and it will make connections to community health resources, both for physical and behavioral health.

Starting Point/Baseline

Baseline Data

This is a new project and the baseline will be zero. Goals will be developed in DY 2 and DY 3.

Time Period for Baseline

TBD

Rationale

Reason for Selection of Project Options and Components

The **2.6.3 Engage Community Health Workers in an Evidence Based Program to Increase Health Literacy of a Targeted Population** project option was selected because CHWs build relationships with their clients and assist them in increasing their health literacy. In addition, there is extensive evidence related to the effectiveness of CHWs in the area of maternal and child health. CHWs assist women and their families to navigate the fragmented system of care and other components of the health care system. CHWs will have in-depth knowledge about their communities and serve as key connectors between underserved communities and the health care system. They also possess the linguistic and cultural skills needed to connect with women from underserved communities who are disconnected from care and have limited knowledge how to navigate the health system.

Reason for Selection of Milestones & Metrics

The Milestones were selected based on reasonable goals for the development and implementation of a new pre/postnatal prevention program. The Metrics are chosen to represent the variety of steps involved in project implementation, including outreach and recruitment of clients within the target population and improvement measures.

Unique Community Need Identification Number

- CN.12 Lack of adequate prenatal care
- CN.17 Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions

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

This is a new initiative.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-8 Perinatal Outcomes
IT-8.2 Percentage of low birth-weight births

Reasons/Rationale for Selecting the Outcome Measure(s)

their will improve access to pre- and post-natal health services. Multiple studies indicate a relationship between the use of prenatal care services and positive birth outcomes. Use of prenatal care has been associated with improved birth weights and the amelioration of the risk of preterm delivery. Studies

indicate that inadequate use of prenatal care has been associated with increased risks of low-birth-weight births, premature births, neonatal mortality, infant mortality, and maternal mortality. Multiple studies indicate the beneficial effects of prenatal care are strongest among socially disadvantaged women. (http://www.cdc.gov/reproductivehealth/ProductsPubs/DatatoAction/pdf/rhow8.pdf)

The use of CHWs will improve access to services and promote effective pre and postnatal services, Participants' outcomes will improve birth outcomes. Low birth-weight is often a predictor of developmental difficulties including health and learning.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

Project shares some common supports with the Healthy Families Project by working together on outreach and serving as a referral for families who might be eligible to participate in the more intensive Healthy Families services. The Healthy Families Program targets families at risk for child abuse and works with families for up to three years post-birth, whereas the Pre/Post Natal program is more broad in its approach and more time-limited.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

20130302.2.4 Healthy Families

List of Related Category 4 Projects *(RHP Project ID Number)*

N/A

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects:

137265806.2.1 - Seton Family of Hospitals: University Medical Center at Brackenridge - OB Navigation
307459301.1.4 - Community Care Collaborative - Expansion of Dental Services
137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation
137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation
307459301.2.5 - Community Care Collaborative - Adolescent and Young Adult Pregnancy Prevention

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives - smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who

are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

The City of Austin HHSD will provide opportunities for learning collaboratives among its RHP Projects and other departmental programs based on commonalities such as prevention programs or target populations. Because the project will need a web of community connections for service delivery to referral points, implementation, and evaluation, HHSD will establish a coalition of formal and informal collaborators and community connections for service delivery to referral points, as well as program planning, design, implementation, and evaluation. The program development will be determined and implemented through an inclusive planning process involving multiple collaborators and stakeholders. Relationships with existing medical providers will have to be cultivated to understand how the different systems work, eligibility requirements, scheduling methods, wait times, and to develop referral and coordination strategies. Ongoing evaluation will be built into the process to make adjustments as needed to improve outcomes.

Additionally, it is important to note that the Austin-area community has an established, respected learning collaborative in place. It is the local Family Support Network that is facilitated by United Way's "Success By 6". It is a group of programs that work with low-income families and children, many of which use home visiting as a service delivery model. The Network partners share resources, training, and problem-solve around common issues in an effort to improve the quality and efficiency of services to at-risk families.

Project Valuation

Approach for Valuing Project

Project valuation was based a portion of the returns of the preventive benefits of the services.

Rationale/Justification for Valuation

Because of the wide variety of preventative savings and the difficulty of assigning a cost to a particular individual, an estimated average cost per client is used. This study calculates the cost effectiveness of adequate prenatal care in reducing the low birth weight rate for each of three socioeconomic groups of women: those with less than 12 years of education, those with 12 years, and those with more than 12 years. Target low birth weight rates for each group were those actually achieved by New Hampshire women receiving adequate prenatal care within respective education groups. The estimated total cost associated with low birth weight births among the 1981-1984 cohorts of New Hampshire resident births was more than $38 million. With universal adequate prenatal care, the low birth weight costs would be less than $32 million, a cost savings of $6.5 million. Since the additional cost of providing adequate prenatal care to all women was estimated to be $2.5 million, the net cost savings were estimated to be $4 million, or $1 million per year. For each additional $1 spent on prenatal care, $2.57 in medical care costs would be saved.

The initial cost of program in year one is $511,495.35. The valuation is based on the ratio that for every dollar ($1) expended the cost value is $2.57. The cost value of the year one will be $1,314,540.40. Valuation was conservatively estimated at 60% the cost value.

Pre and postnatal interventions can prevent or ameliorate a number of complications that can impact the child and family for years and increase costs of health care including the cost of remediation of developmental delays. Other community costs include educational consequences. Potential savings are

significant especially in preventing low and very-low birth-weight deliveries in which the infant has to be cared for in a neonatal intensive care unit.

As explained above, the valuation was calculated as an estimated value. As noted 60% of the value was used as conservative proposed value. As a preventative project the exact value cannot be determined except by an estimate. Some preventative benefits stay with the child beyond the end of the program.

http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_cost-offset.pdf
http://www.epa.gov/opptintr/coi/pubs/iii_2.pdf
http://www.cdc.gov/diabetes/projects/comm.htm

201320302.2.4	*2.6*	*2.6.3*	***PRENATAL, POSTNATAL PROGRAM***	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT				**201320302**
Related Category 3 Outcome Measure(s):	201320302.3.4	IT-8.2	Percentage of low birth-weight births	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*RHP PP Milestone* – P-Y]: P-2 Development of evidence-based projects for targeted populations based on distilling the needs assessment and determining priority of interventions for the community Metric 1 P-2.1: Document innovational strategy and plan Plan, outreach, intervention, partnerships, services, timeline developed and documented Data Source: Documented plan and activities Milestone 1 Estimated Incentive Payment *(maximum amount):* $224,866 **Milestone 2** : P-X Staff hired, oriented, and trained. Metric 1 : Number of staff completing orientation/training. Baseline/Goal: 0 / 2 staff Program Supervisor and Program Coordinator hired, oriented, and trained Data Source: Personnel and training records Milestone 2 Estimated Incentive Payment: $224,866	**Milestone 3** : P-X Staff hired, oriented, and trained. Metric 1 : Number of staff completing orientation/training. Baseline/Goal: 2 / 8 staff Six contract based outreach workers (CHWs) hired, oriented, and trained Data Source: Personnel and training records Milestone 3 Estimated Incentive Payment: $159,772 **Milestone 4** [I-1]: I-6 Number of patients in defined population receiving innovative intervention consistent with evidence-based model Metric 1 [I-1.2]: Number of patients receiving innovative intervention Goal: 75 patients Data Source: Patient records Milestone 6 Estimated Incentive Payment: $159,772 **Milestone 5**: P-X Conduct rapid evaluation of client outreach and interventions. Metric 1 [P-8.1]: Baseline/Goal: 1 / 3 cycles of		**Milestone 7** [I-1]: I-6 Number of patients in defined population receiving innovative intervention consistent with evidence-based model Metric 1 [I-1.2]: Number of patients receiving innovative intervention Goal: 100 patients Data Source: Patient records Milestone 6 Estimated Incentive Payment: $223,549 **Milestone 8**: P-X Conduct rapid evaluation of client outreach and interventions. Metric 1 [P-8.1]: Baseline/Goal: 1 / 3 cycles of evaluation and improvements Data Source: Evaluation documents, client and stakeholder surveys Milestone 7 Estimated Incentive Payment: $223,549 **Milestone 9**: P-8. Participate in face-to-face learning meetings or seminars at least twice a year with other providers and the RHP to promote collaborative learning around shared or similar projects. Identify and agree upon and commit to improvements	**Milestone 10** [I-1]: I-6 Number of patients in defined population receiving innovative intervention consistent with evidence-based model Metric 1 [I-1.2]: Number of patients receiving innovative intervention Goal: 150 patients Data Source: Patient records Milestone 9 Estimated Incentive Payment: $210,401 **Milestone 11**: P-X Conduct rapid evaluation of client outreach and interventions. Metric 1 [P-8.1]: Baseline/Goal: 1 / 3 cycles of evaluation and improvements Data Source: Evaluation documents, client and stakeholder surveys Milestone 10 Estimated Incentive Payment: $210,401 **Milestone 12**: P-8. Participate in face-to-face learning meetings or seminars at least twice a year with other providers and the RHP to promote collaborative learning around shared or similar projects. Identify and agree upon and commit to improvements

201320302.2.4	*2.6*	*2.6.3*	***PRENATAL, POSTNATAL PROGRAM***	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT				**201320302**
Related Category 3 Outcome Measure(s):	201320302.3.4	IT-8.2	Percentage of low birth-weight births	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	evaluation and improvements Data Source: Evaluation documents, client and stakeholder surveys Milestone 4 Estimated Incentive Payment: $159,772 **Milestone 6** P-8: Participate in face-to-face learning meetings or seminars at least twice a year with other providers and the RHP to promote collaborative learning around shared or similar projects. Identify and agree upon and commit to improvements that all providers can do to "raise the floor" for performance. .P-8.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the Provider, RHP, or Success By 6. a. Data Source: Documentation of meetings including agendas and/or meeting notes. P-8.2. Metric: Implement the "raise the floor" improvement initiatives. a. Data Source: Documentation of agreed upon improvement initiatives and documentation of implementation. Milestone 5 Estimated Incentive Payment: $159,772		that all providers can do to "raise the floor" for performance. .P-8.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the Provider, RHP, or Success By 6. a. Data Source: Documentation of meetings including agendas and/or meeting notes. P-8.2. Metric: Implement the "raise the floor" improvement initiatives. b. Data Source: Documentation of agreed upon improvement initiatives and documentation of implementation. Milestone 8 Estimated Incentive Payment: $223,549	that all providers can do to "raise the floor" for performance. .P-8.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the Provider, RHP, or Success By 6. a. Data Source: Documentation of meetings including agendas and/or meeting notes. P-8.2. Metric: Implement the "raise the floor" improvement initiatives. c. Data Source: Documentation of agreed upon improvement initiatives and documentation of implementation. Milestone 11 Estimated Incentive Payment: $210,401

201320302.2.4	*2.6*	*2.6.3*	***PRENATAL, POSTNATAL PROGRAM***
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			**201320302**
Related Category 3 Outcome Measure(s):	201320302.3.4	IT-8.2	Percentage of low birth-weight births

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $449,732	Year 3 Estimated Milestone Bundle Amount: $639,088	Year 4 Estimated Milestone Bundle Amount: $670,647	Year 5 Estimated Milestone Bundle Amount: $631,203
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**			$2,390,670

City of Austin Health and Human Services Department (HHSD)
HEALTHY FAMILIES EXPANSION
201320302.2.5 Pass 2

Provider: City of Austin Health and Human Services Department is the local health authority that has public health jurisdiction over Austin/Travis County with a population of 1,024,266 residents. The Department has two immunization clinics, one refugee clinic and one STD clinic. In addition, the Department provides preventive health services, programming and education; policy, systems, and environmental health recommendations; emergency preparedness and response; neighborhood center operations and contracting for social services with community agencies.

Intervention(s): The Project will provide home visiting and family support services based on the evidence-based Healthy Families America model to improve families' access to preventive services including establishing a medical home, immunizations, well-child checks, developmental assessments, parenting education, and home and personal safety practices such as car seats. Patient impact and outcomes are expected to include, but not limited to:

- An established Medical Provider
- Injury and disease prevention
- Age-appropriate child development
- Utilization of appropriate area resources

Need for the project: African American children are almost three times as likely to suffer child abuse as other children. Incidence of child abuse is exacerbated by certain stressors, which include poverty, family history of violence, drug or alcohol abuse, poverty, chronic health problems, and lack of social supports. *(www.cdc.gov/violenceprevention)* Case management through family visiting that encourages healthy responses to stressors and increases access to social and medical services has been proven to result in healthier outcomes for all members of the family.

Target population: The service population is at-risk families that are expectant or new parents, especially first-time parents with outreach targeted to African-American families. The families who are deemed eligible for home visiting services have multiple stressors/risk factors as described above. Poverty is one of the most common stressors. Project goals will be determined in Year 2, but it is estimated average 60 children and their families will be served per year. An estimated minimum of 80% of families, or about 48 children and their families including siblings, served will be within the Medicaid income guidelines.

Category 1 or 2 expected patient benefits: number of families to receive innovative intervention consistent with evidence-based Healthy Families model. Goal to be determined in Year 2, but estimated at 60 families per year for years 4 and 5.

Category 3 outcomes:

IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Non-standalone measure). To be determined in Year 2 but after identification of the gap, the estimated goal is to lessen the low birth rate disparity by at least 5% per year.

IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure): Goal is to improve the rates for services such as medical home and immunizations from the rate at intake (TBD) to a minimum of 95%.

IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. (Non-standalone measure). Improvement goals will be established in Year 2 including a goal to increase client satisfaction from year to year.

Title of Project: **HEALTHY FAMILIES EXPANSION**

Category / Project Area / Project Option: **2.7.6 Other project option: Implement other evidence-based project to implement evidence-based disease prevention programs in an innovative manner not described in the previous project options.**

RHP Project Identification Number: **201320302.2.5 Pass 2**

Performing Provider Name: **City of Austin Health and Human Services Department (HHSD)**

Performing Provider TPI: **201320302**

Project Description

Overall Project Description

City of Austin HHSD proposes to provide home visiting and family support services based on the evidence-based Healthy Families America model to target African-Americans who are expectant or new parents, especially first-time parents, in order to promote healthier developmental outcomes.

The Project would improve families' access to preventive services including establishing a medical home, immunizations, well-child checks, developmental assessments, parenting education, and home and personal safety practices such as car seats. These benefits are detailed in the Goals section below.

Travis County's established Healthy Families Program will be expanded by adding a unit of home visitors to provide the services with a significant redesign in the outreach and recruitment modalities in order to attract and retain African-American families. African-American families have comprised a small percentage of Travis County's Healthy Families clients, who number approximately 200 at present; the new service unit established through the expansion will have the goal of serving a higher percentage of African-American families. An estimated 28 children and their families will be served with additional families added as turnover occurs. About 25% turnover is anticipated in the second year and 50% by the third year. Approximately 60 families per year will be assessed. Those families not enrolled in Healthy Families will be referred to other home visiting programs or social service programs as appropriate. Historically, about half of the parents enrolled in the Healthy Families program (all races/ethnicities) are teen parents.

Families are identified and referred to the Healthy Families project mainly through community partner referrals. In contrast with the City of Austin's proposed Prenatal/Postnatal Program, Healthy Families clients are at higher risk for child abuse and neglect. Once referred to a Healthy Families specialist, families will be screened and enrolled as appropriate. The Project's implementation process will include hiring and training staff including a coordinator, outreach specialist, and home visitors. Project staff in coordination with community stakeholders will develop a new outreach plan using the best practices of the existing program while adding new tactics to reach the target population. The development of new strategies will involve community partners. Once active outreach, recruitment, and services begin an ongoing evaluation process will capture feedback from staff, stakeholders, and clients, both those successfully engaged and those who left the program early. The frequent feedback – evaluation cycle will allow for improvements to be made to project components.

The Project will adhere to the evidence-based home visiting model developed by Healthy Families America. As such, observation of the parent and child's relationship is one of the most critical features of each home visit. During these visits, the home visitors teach information about parenting and child development in order to help strengthen this important bond. Research indicates that the stronger the bond between parents and their children, and the more understanding a parent has about their child's development, the less likely they are to abuse or neglect their child. At intake, the Supervisor/Family Assessment Worker assesses each family to identify strengths and needs. Families are provided with helpful referrals to community resources, which may include the home visiting services also. The families who are deemed eligible for home visiting services have multiple stressors. These may include concerns such as: lack of adequate housing, limited or no income, history of child abuse, domestic violence, substance abuse, health concerns, mental health issues, transportation barriers and language barriers. Services are voluntary, intensive, and may last until the baby is 3 years old. The visits begin on a weekly basis for the baby's first year of life, then decrease to every other week, then monthly, and quarterly as the baby gets older and the family gains more self-sufficiency. Every 3 months, family goals are reviewed. Every 6 months, the family creates new goals – both for themselves and for their baby. The number of cases that the home visitor can manage is determined by the age of the child since the frequency and intensity lessen as the child ages unless there are circumstances such as disabilities that may require more frequent involvement. Caseloads are 12 to 15 families with infants and increase with a greater mix of ages. Additionally, all home visitors are trained to provide screenings on the children to assess their growth and developmental milestones. If any child is identified to have a concern or concerns in any of these areas, they are referred to Early Childhood Intervention services.

Project Goals

Improved child health and promote age appropriate development for infants/children from low-income families with a focus on increasing services to African-American families.

Expected goals from the delivery of comprehensive services are listed below. Families that receive case management services develop a trusting relationship that augments the parents' assets.

- An established Medical Provider will assist the family in meeting the health needs of both child and parents with expected collateral outcomes such as: age appropriate immunizations, well child exams, and identification and treatment of postpartum depression. Families will choose a provider from available clinics and independent providers with the assistance of the case manager.
- Injury and disease prevention will reduce the use of emergency room and urgent care medical visits due to having an established medical provider (medical care before crisis), immunizations on schedule, better family nutrition including breastfeeding, and no substantiated instances of child abuse or neglect thereby preventing medical care associated with intentional injuries or neglect of health issues.
- Age-appropriate child development will be assessed by parental and home visitor's observations and by screening tools such as the Denver and Ages & Stages. Physical or other developmental problems tend to have reduced long-term impacts if identified and treated early.
- Utilize appropriate area resources parents become advocates for their child and family by finding community resources if their child's assessment shows a developmental delay or if family members have other needs such as health, counseling, or employment services. Mental health referrals are commonly made to community based organizations in the area of domestic violence issues or in-home counseling services, as well as to food pantries, educational opportunities, housing, child care, literacy

services, and prenatal education classes. Basic needs referrals are made directly to Travis County's Basic Needs Program for assistance with rent, utilities, food, and burial.

Relationship to RHP 7 Goals

- RHP Goal 1: Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
- RHP Goal 5: Support prevention education and healthy lifestyles

Challenges or Issues Faced by the Performing Provider

The primary challenges are how to engage African-American parents that encourages their participation in the program for the first few years of their child's life as well as developing a trusting relationship.. African-American families are approximately 5% of the current Healthy Families caseload.

How the Project Addresses those Challenges

Changing this dynamic will require the new Program to establish cooperative community connections including faith communities, School Support Services including teen parent programs, and HHSD's own programs such as childhood immunizations, Neighborhood Centers, WIC Clinics, and its African American Quality of Life Initiative. It will be of critical importance to hire and train culturally-competent staff with the ability to establish trusting relationships with the families. Outreach and recruitment will need to be designed to identify families within the target population, and then provide a service model that is attractive enough to engage and retain the families. Flexibility in the program model will be needed. For example, if a family is initially uncomfortable with the home visit method, other meeting places may be arranged until the family invites the program into their home. The approach will need to take a multidisciplinary life course perspective. Frequent evaluation of outreach efforts, collaborative referral partners, and community input will allow critical adjustments to improve outreach and retention. For just this reason, a "Plan, Do, Study, Act" cycle is included.

How the Project is Related to RHP Goals

While the Project touches many of the RHP goals, it is most related to Regional Goal #5: Support prevention education and healthy lifestyles to improve population health.

- The case management by home visitors will educate parents and children about healthy practices and make connections to community health resources, both for physical and behavioral health.
- Establishing a medical home and utilization of other preventative measures such as immunizations, well-child checks, and home safety also address the goal.

Starting Point/Baseline

Baseline Data

Travis County currently has two cohorts enrolled in its Healthy Families program. These enrolled cohorts had 229 children.

Time Period for Baseline

These cohorts were enrolled in FY 2011, and FY 2012 projected to be about the same.

Rationale

Reason for Selection of Project Options and Components

2.7.6- This project option was selected to provide flexibility for the Healthy Families Program since it addresses overall family health issues in a holistic approach to the child and family including prenatal care, birth outcomes, well child check-ups/screening, immunizations, post-partum depression, home safety and hygiene practices, nutrition, child development, and parenting skills.

Reason for Selection of Milestones & Metrics

The Milestones were selected based on what are reasonable goals for the development and implementation of a new Healthy Families Unit. The Metrics are chosen to represent the variety of steps involved in project implementation including outreach and recruitment of clients within the target population and improvement measures.

Unique Community Need Identification Number

CN.16: Lack of services for specific populations such as: Homeless; Children; Aging and elderly

CN.17: Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions

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

The expansion uses the existing Healthy Families program operated by Travis County HHS&VS, but adds a new case management/home visiting unit and a focus on African-American families. The Project will serve additional clients, and underserved population. The City of Austin HHSD does not currently fund Healthy Families. Funding the Expansion Project is a new initiative for the City of Austin.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

None identified.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measure(s) Selected

OD-11

IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Non-standalone measure)

IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure)

IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. (Non-standalone measure)

Reasons/Rationale for Selecting the Outcome Measure(s)

The target population has significant health disparities as noted in the local HHSD's ***2012 Critical Health Indicators Report*** for Austin/Travis County:

"Maternal, Child, and Adolescent Health in Travis County

- From 2006 to 2008 the percentage of mothers who identify as Black and Hispanic with "Late or No Prenatal Care" was over twice that of White mothers from 2006 to 2008.

- Late initiation of prenatal care or no prenatal care are often related to a mother's ability to access medical care.
- Babies born to Black mothers were at highest risk among the three race/ethnicity groups to be born premature or with a low birth weight.
- Hispanic and Black females younger than 20 years old (including the 15-17 year old subset of females) had the highest percent of births to teen mothers – approximately 4 to 8 times the percent for White mothers.
- Blacks experience the highest rates of infant mortality, twice that of Hispanics and Whites."

Utilization of preventative services supported by increasing health literacy of parents can be an effective change agent in improving health outcomes and reducing disparities. Recognition of the change in quality of life as including satisfaction with project services is an outcome that may impact continued participation in preventative health and safety practices.

Engage overburden African American families in the home visiting service prenatally and at birth, cultivates and strengthens nurturing parent/child relationships and promotes healthy childhood growth and development. Providing families with linkages to medical homes and community resources and monitoring the development of participating infants and children; enhance family functioning by reducing the risk, overcoming barriers, and building protective factors. By improving birth outcomes and nutrition, we have better probability of having a positive impact in decreasing infant mortality rate and low-birth rate.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The Project can extend services to clients from the Prenatal/Postnatal Project for client families that are identified to be at-risk and are referred to Healthy Families for ongoing service.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*
Prenatal/Postnatal – 20130302.2.4

List of Related Category 4 Projects *(RHP Project ID Number)* N/A

Relationship to Other Performing Providers' Projects in the RHP

133340307.2.11 - Hill Country MHDD Centers - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Family Partner
137265806.2.1 - Seton Family of Hospitals: University Medical Center at Brackenridge - OB Navigation
137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation
137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation
307459301.2.5 - Community Care Collaborative - Adolescent and Young Adult Pregnancy Prevention

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives - smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

The City of Austin HHSD will provide opportunities for learning collaboratives among its RHP Projects and other departmental programs based on commonalities such as prevention programs or target populations.

It is important to note that the Austin-area community has an established, respected learning collaborative in place in which the Healthy Families Program participates. It is the local Family Support Network that is facilitated by United Way Success By 6. It is a group of programs that work with low-income families and children many of which use home visiting as a service delivery model. The Network partners share resources, training, and problem-solve around common issues in an effort to improve the quality and efficiency of services to at-risk families.

Project Valuation

Approach for Valuing Project

Valuation is an estimate of the cost savings and/or cost effectiveness of the combination of the variety of services provided to client children, siblings, and adults.

Rationale/Justification for Valuation

The case management model of Healthy Families works as both an early intervention model and as a prevention program while responding to an individual family's needs as presented. Healthy Families has a history of positive outcomes in preventative health coupled with behavioral health such as child abuse/neglect prevention that prevents intentional and unintentional injuries. It also works on home safety and hygiene such as food preparation, infant/child car seat use, and even something as obvious as frequent diaper changes to avoid rash and infection.

Also incorporated into valuation calculations was the following treatment of the costs of child abuse: *"A new study of the economic burden of child maltreatment in the United States calculated that the lifetime costs of child maltreatment are $210,012 per child in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs. The estimated average lifetime cost per death is $1,272,900, including $14,100 in medical costs and $1,258,800 in productivity losses. The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States in 2008 is approximately $124 billion."*

> *Fang, X., Brown, D.S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect, 36(2), 156-165.*

Well child services including immunizations have been shown in some studies to provide cost offsets and/or cost savings from the provision of timely preventative care. http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_cost-offset.pdf

PROJECT **201320302.2.5**	***PROJECT OPTION*** ***2.7.6***	***PROJECT COMPONENTS*** ***N/A***	***HEALTHY FAMILIES EXPANSION***
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			**TPI: 201320302**
Related Category 3 Outcome Measure(s): **201320302.3.5** **201320302.3.6** **201320302.3.7**	OD-11 OD-11 OD-11	IT-11.2 IT-11.3 IT-11.4	IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Non-standalone measure) IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. (Non-standalone measure)

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-2 Implement evidence-based innovational project for targeted population. Metric 1: P-2.1 Document implementation strategy and testing outcomes. FY12 Baseline is 229 children Healthy Family Unit with new emphasis on outreach to African-American population Documentation of implementation to include: • Work statement development • Contract in place (estimate 4/1/13) • Develop outreach and retention plan with community stakeholder input • Hire and train staff o Supervisor/Family Assessment Worker (50/50%) o Caseworkers (2)	**Milestone 3**: I-5 Identify number of of clients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1: Increase in number of families served by race/ethnicity who achieve the following outcomes: •An established Medical Provider •Injury and disease prevention •Age-appropriate child development •Utilize appropriate area resources Goal: 50 additional children over baseline Data Source: Travis County Healthy Families Milestone 3 Estimated Incentive Payment: $157,500 **Milestone 4**: P-7. Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers (including the existing Healthy Families statewide meetings	**Milestone 5**: I-5 Identify increase in number of clients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1: Increase in number of families served by race/ethnicity who achieve the following outcomes: •An established Medical Provider •Injury and disease prevention •Age-appropriate child development •Utilize appropriate area resources Goal: 75 additional children over baseline Data Source: Travis County Healthy Families Milestone 5 Estimated Incentive Payment: $93,333 **Milestone 6**: P-X.1 Implement outreach plan to target population including evaluation at least monthly Metric 1 [P-8.1]: Baseline/Goal: 0/1-Plan	**Milestone 8**: I-5. Identify increase in number of clients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1: Increase in number of families served by race/ethnicity who achieve the following outcomes: •An established Medical Provider •Injury and disease prevention •Age-appropriate child development •Utilize appropriate area resources Goal: 100 additional children over baseline Data Source: Travis County Healthy Families Milestone 8 Estimated Incentive Payment: $81,667 **Milestone 9**: P-X.1 Implement outreach plan to target population including evaluation at least monthly Metric 1 [P-8.1]: Baseline/Goal: 0/1-Plan

PROJECT **201320302.2.5**	***PROJECT OPTION*** ***2.7.6***	***PROJECT COMPONENTS*** ***N/A***	***HEALTHY FAMILIES EXPANSION***
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			**TPI: 201320302**
Related Category 3 Outcome Measure(s): **201320302.3.5** **201320302.3.6** **201320302.3.7**	OD-11 OD-11 OD-11	IT-11.2 IT-11.3 IT-11.4	IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Non-standalone measure) IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. (Non-standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
• Inventory of outreach efforts Goal: New Healthy Family Unit implemented, first clients enrolled and receiving services. Data Sources: Project Design documents/meeting notes, Work Statement including performance reporting, and Contract with Travis County Healthy Families Milestone 1 Estimated Incentive Payment: $175,000 **Milestone 2**: P-X.1 Implement outreach plan to target population including evaluation at least monthly <u>Metric 1</u> [P-X.1]: Baseline/Goal: 0/1-Plan documented and implemented evidence by # outreach contacts and # of monthly evaluation sessions Data Source: Travis County Healthy	including Houston, Dallas, and San Angelo programs; and, the Family Support Network that is facilitated by Success By 6) and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 P-7.1. Participate in semi-annual face-to-face meetings or seminars organized by the RHP. a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 P-7.2. Implement the "raise the floor" improvement initiatives established at the semiannual meeting. a. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each	documented and implemented evidence by # outreach contacts and # of monthly evaluation sessions Data Source: Travis County Healthy Families Milestone 6 Estimated Incentive Payment: $93,333 **Milestone 7**: P-7 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers (including the existing Healthy Families statewide meetings including Houston, Dallas, and San Angelo programs; and, the Family Support Network that is facilitated by Success By 6) 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.	documented and implemented evidence by # outreach contacts and # of monthly evaluation sessions Data Source: Travis County Healthy Families Milestone 9 Estimated Incentive Payment: $81,667 **Milestone 10**: P-7 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers (including the existing Healthy Families statewide meetings including Houston, Dallas, and San Angelo programs; and, the Family Support Network that is facilitated by Success By 6) 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.

PROJECT **201320302.2.5**	***PROJECT OPTION*** ***2.7.6***	***PROJECT COMPONENTS*** ***N/A***	***HEALTHY FAMILIES EXPANSION***
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			**TPI: 201320302**
Related Category 3 Outcome Measure(s): **201320302.3.5** **201320302.3.6** **201320302.3.7**	OD-11 OD-11 OD-11	IT-11.2 IT-11.3 IT-11.4	IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Non-standalone measure) IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. (Non-standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Families Milestone 2 Estimated Incentive Payment: $175,000	semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 4 Estimated Incentive Payment: $157,500	Metric 1 P-7.1. Participate in semi-annual face-to-face meetings or seminars organized by the RHP. a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 P-7.2. : Implement the "raise the floor" improvement initiatives established at the semiannual meeting. a. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 7 Estimated Incentive Payment: $93,333	Metric 1 P-7.1. Participate in semi-annual face-to-face meetings or seminars organized by the RHP. a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 P-7.2. Implement the "raise the floor" improvement initiatives established at the semiannual meeting. a. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 10 Estimated Incentive Payment: $81,667
Year 2 Estimated Milestone Bundle Amount: $350,000	Year 3 Estimated Milestone Bundle Amount: $315,000	Year 4 Estimated Milestone Bundle Amount: $279,999	Year 5 Estimated Milestone Bundle Amount: $245,001
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,190,000			

City of Austin Health and Human Services Department

Adult Immunizations to High Risk Populations

201320302.2.6 Pass 2

Provider: City of Austin Health and Human Services Department is the local health department with public health jurisdiction over Austin/Travis County and its 1,024,266 residents. The Department provides preventive health services, programming and education; policy, systems, and environmental health recommendations; emergency preparedness and response; neighborhood center operations and contracting for social services with community agencies. In addition, the Department has two immunization clinics, one refugee health clinic and one TB/STD clinic. STD and immunization clinics overwhelmingly serve Medicaid, Medicaid eligible, and indigent care populations.

Intervention(s): Currently, City of Austin Immunizations Program provides immunization services two mornings per week at the City of Austin STD clinic. This project will expand the number of hours immunization services are available at the STD clinic and increase the formulary of vaccines available to STD clinic patients. Secondly, the project will establish relationships with community organizations that serve certain high risk populations to provide immunization services to their clients at those organizations' locations.

Need for the project: Populations noted in the "target outreach" section below are challenged with unique and endemic barriers to accessing preventative care. Client barriers include: transportation, perceived cost and value of vaccines, language, disease stigma, concerns regarding privacy, lack of health insurance coverage and/or affordable access, and low information regarding disease transmission. Providers report experiencing barriers in providing immunizations due to cost of vaccines, management of vaccine inventories, resource challenges and competing health administration priorities.

There are a significant number of individuals potentially in need of access to these low/no cost vaccination services in Travis County. Utilizing a formula provided by the Texas DSHS, the City of Austin HHSD estimates the total population of MSM at approximately 47,000 individuals. It is also estimated that there are approximately 19,221 individuals living with HIV/AIDS in Travis County. In addition, it's estimated that 24% of residents lack health insurance and 16% report cost as a barrier to care. Homeless populations are estimated to be between 2,000 and 4,000. In addition, the Health and Human Services Department currently provides HIV and STD/TB screening and treatment to approximately 15,000 clients annually, of which most can be considered high value targets to receive the proposed vaccinations. The immunization program proposes to provide services to clients that lack access to or cannot obtain health insurance coverage; and/or are underinsured and cannot afford co-pays and deductibles. Research indicates that targeted outreach campaigns can increase interest in receiving vaccinations.

Target population: The HHSD immunization program seeks to increase the provision of vaccines to decrease morbidity and mortality focusing on the following high-risk populations that include the homeless, men who have sex with men (MSM), women at risk (including pregnant women), substance abusers (including intravenous drugs), LGBT youth, HIV positive individuals and people that smoke..

Category 1 or 2 expected patient benefits: This project seeks to expand vaccination services to vulnerable adults.

Category 3 outcomes: IT 11.1: Improvement in Clinical Indicator in identified disparity group: increase in clinic utilization rate.

Title of Project: Adult Immunizations to High Risk Populations

Category / Project Area / Project Option: Category 2/Intervention 7: Implement Evidence-based Disease Prevention Programs

RHP Project Identification Number: 201320302.2.6 Pass 2

Performing Provider Name: City of Austin Health and Human Services Department

Performing Provider TPI: 201320302

Project Description

Overall Project Description

Through this DSRIP Project, the City of Austin Health & Human Services Department will target vaccinations to vulnerable adult populations at increased risk for vaccine preventable diseases, thereby decreasing disease incidence. For certain high-risk adult populations who have little interaction with the healthcare system, providing vaccinations where services are already sought will increase immunization rates and prevent disease. This will be accomplished in two ways: adults seeking services at the STD clinic who are at increased risk of contracting hepatitis A, HPV, influenza, and pneumonia will be offered immediate vaccinations when available, and scheduling or referrals to other vaccination sites when necessary. Additionally, adults who seek services targeted to high-risk populations will be offered vaccinations from an outreach LVN. This program expects to serve a minimum of 3750 adult clients annually.

Currently, limited vaccination services are provided two mornings per week at the City of Austin's HHSD's STD clinic. In 2009 HHSD began a referring high-risk clients from the HHSD STD/HIV clients to the adult immunization program located off site. In 2011 the immunization program provided a part-time nurse onsite at the HHSD STI clinic and the number of immunizations increased significantly; however the project currently operates fewer than 10 hours per week with a throughput estimated at a four clients per hour.

In 2011 HPV and hepatitis A vaccine were removed from the adult DSHS safety net formulary. The City and/or State were still able to provide flu, tetanus, diphtheria, pertussis, and hepatitis B to clients. The program has received a limited number of HPV vaccine donated from area providers and has made a small purchase of pneumococcal. The program seeks to restore and expand vaccinations with a complete formulary vaccines as noted earlier for adult clients screened or served at the HHSD STI clinic and also to clients seeking non-clinical support with collaborative partners targeting high risk clients.

Secondly, the program proposes to establish collaborative agreements with Travis County agencies currently providing services to complex-need populations (i.e. homeless, HIV infected) to promote, refer and implement our vaccination services onsite (as permitted). This may include agencies such as drug treatment centers, AIDS service centers, centers for LGBT youth, and agencies serving homeless populations. Specifically, the program proposes to expand the collaborative agreements with one new agency serving a

different population target annually. Finally, the program will evaluate the effectiveness of our vaccination efforts with client feedback instruments and by tracking clinic utilization rates.

Research noted below demonstrates the need to target vaccination efforts based on a population's unique complexities and vulnerabilities.

An article published by the Centers for Disease Control summarizes current (as of 2011) guidelines and recommends our proposed integrated approach, where immunizations are provided at sites where services to these high-risk populations are also. From the November 9th MMWR the following recommendations are noted: "*Hepatitis A vaccination is recommended for persons who use drugs illicitly. Hepatitis B vaccination is recommended for all adults in certain settings, including STD clinics, HIV testing and treatment facilities, facilities providing substance abuse treatment and prevention services, correctional facilities, and health-care settings serving persons who inject drugs illicitly.*" http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm

Specifically, the HHSD immunization program seeks to increase the provision of vaccines administered and immunization referrals to decrease morbidity and mortality within the following high-risk populations: homeless populations, Men who have Sex with Men (MSM), women at risk, substance abusers, lesbian/gay/transgender youth (LGBT), HIV positive and smokers. These populations will be identified and then referred to testing and vaccinations according to CDC protocol.

Project Goals

The program's primary goal will be to provide approximately 3750 vaccination appointments to high-risk populations annually. On average we expect each individual to receive between two and three vaccinations; however, doses administered will differ based upon each client's risk factors and vaccination history. With the requested administrative support to the immunization nurse the program will be able to provide recall and reminder services to help clients complete their immunization series, when applicable. The five year project goal is to increase access to vaccinations for clients seeking STD clinical services by 2% annually, subsequently immunizing 11,600 clients within the high-risk population groups.

Challenges or Issues Faced by the Performing Provider

The primary challenges for the program will be to identify and establish new collaborative relationships with community partners providing social support services (non-clinical) to these high-risk populations, such as providers of services for substance abusers. In addition, the program will need to build upon and expand current collaborations within our Communicable Disease Unit; that allows immunization services to be provided in a seamless transition for the client.

The program will work to address barriers faced by populations we plan to serve. Client barriers to clinical services to high risk communities include the following transportation, perceive value of vaccines, language, disease stigma, concerns of privacy, lack of health insurance, and low information regarding disease transmission.

How the Project Addresses those Challenges

The City of Austin has extensive collaborations with many of the community-based organizations serving populations the program seeks to target. The immunization program will reach out to new partners with limited clinical service capacities and leverage existing partnerships with community-based organizations that serve the populations at risk. We will offer flexible scheduling options with little or no impact to an agency's operating procedures. Our experience when providing our vaccination services to a local substance abuse treatment facility was very well received by the agency staff management who expressed gratitude in being able to provide meaningful disease prevention services to their clients.

Many of the barriers experienced by clients can be bridged if our program can provide convenient access for clients at the facility where they are already seeking other supportive services. Staff working with these population groups will be fluent in Spanish with specific knowledge, experience and skills regarding the challenges these populations face. Health education professionals are also on staff to work with the community based organizations and outreach staff to explain the value of vaccinations and provide technical support when needed.

Goals and Relationship to Regional Goals:

Increasing the vaccination rate of high risk adults will achieve the following Region 7 goals:

- Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
- Goal 5: Support prevention education and healthy lifestyles to improve population health.

Starting Point/Baseline

Baseline Data: The immunization program is currently providing a limited number of vaccinations and appointments to adult clients seeking care in the HHSD HIV/STD clinic. The immunization program is proposing to provide an estimated 3750 appointments annually, an estimated reach of 28% of the HHSD clients seeking STI/HIV clinical services. The program has been able to serve 1200 clients in a 12-month period with approximately 30% of the proposed capacity.

Time Period for Baseline: The immunization program will collect data in accordance the with City's fiscal year which begins October 1st. Data will be reported quarterly and begin with program commencement.

Rationale

Reason for Selection of Project Options and Components

Implement Evidence-based Disease Prevention Programs

Project Goal:
Implement innovative evidence-based strategies in disease prevention areas including the following: diabetes, obesity, tobacco use, prenatal care, birth spacing, and health screenings.

We selected project option 6, "other" because options didn't recognize role that immunizations play in promoting population health.

Reason for Selection of Milestones & Metrics

Process Milestone P-X: Hire personnel; obtain medical resources to begin implementing program to target high risk populations which include Medicaid, Medicaid eligible and indigent populations.

- In preparation to complete the milestone (which is to successfully implement an expansion of services) the program will need to move through a hiring process to identify a qualified candidate as well as obtain medical supplies, including vaccines.

Improvement Milestone I-7: Increase access to disease prevention programs using innovative project option; Metric I-7.2: Increased number of encounters as defined by intervention

- This milestone and metric will quantify the additional vaccination appointments provided as a result of this expansion.

Unique Community Need Identification Number

CN.6 Inadequate services throughout the continuum of care for individuals with behavioral health issues such as:

- Prevention and supported recovery
- Screening, outpatient treatment, and integrated care
- Intensive outpatient, supported housing, and residential treatment
- Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care

CN.7 Lack of coordination of care across:

- Settings of care
- Multiple conditions
- Physical and behavioral health

CN.14 Rising incidence of vaccine preventable conditions

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

The immunization program is currently providing a limited number of vaccinations and appointments to adult clients seeking care in the HHSD HIV/STD clinic. In FY 2011 the program was able to serve approximately 1100 clients during an estimated 240 clinic hours.

Minimally, this program expansion will double the number of hours of immunization services available in the STD clinic. One LVN has the capacity to serve up to five clients per hour. Based on throughput rates we will have the capacity to serve 3,360 clients in a 48 work week year, with 16 hours of availability each week. As noted above the program will expand the current formulary of vaccines by adding hepatitis A,

HPV, pneumococcal and influenza. The program will also expand outreach partnerships with community-based organizations currently providing non-clinical services to these high-risk populations.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

An adult safety net program funded through DSHS does provide for certain vaccines for adults; however currently there is no provision of HPV, pneumococcal or Hep A; and the vaccine formulary is subject to change depending on state funding levels. The Vaccines for Children program, which is funding passed through the Texas Department of State Health Services from the Centers for Disease Control does allow an adult (19 years) to complete a vaccination series which began when the individual was 18 years or younger.

The proposed funding will allow our program to bridge funding and formulary gaps for immunizations to ensure high-risk clients have access to a comprehensive and necessary formulary of vaccines.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD- 11 Addressing Health Disparities in Minority Populations

IT-11.1 Improvement in Clinical Indicator in identified disparity group.

- Provision of vaccination and/or completion of vaccine series to adult identified as high risk

Reasons/Rationale for Selecting the Outcome Measure(s)

The indicator has also been identified nationally by the Healthy People 2020 Immunization-related Objectives and the CDC as noted below:

- Objective IID-13: Increase the percentage of adults who are vaccinated against pneumococcal disease.
  - Sub-objective IID-13.1: Noninstitutionalized adults aged 65 years and older
  - Sub-objective IID-13.2: Noninstitutionalized high-risk adults aged 18 to 64 years
- Objective IID-15: Increase hepatitis B vaccine coverage among high-risk populations.
  - Sub-objective IID-15.2: (Developmental) Men who have sex with men
  - Sub-objective IID-15.4: (Developmental) Injection drug users
- Objective IID-25: Reduce hepatitis B
  - Sub-objective IID-25.1: Reduce new hepatitis B infections in adults aged 19 and older
  - Sub-objective IID-25.2: Reduce new hepatitis B infections among high-risk populations-Injection drug users
  - Sub-objective IID-25.3: Reduce new hepatitis B infections among high-risk populations-Men who have sex with men
- Objective IID-12: Increase the proportion of children and adults who are vaccinated annually against seasonal influenza.
  - Sub-objective IID-12.6: Noninstitutionalized high-risk adults aged 18 to 64 years
  - Sub-objective IID-12.7: Noninstitutionalized adults aged 65 years and older
  - Sub-objective IID-12.10: Pregnant women

This CDC also recommends HPV for gay and bisexual men (or any man who has sex with a man). It is also recommended for men and women with compromised immune systems (including people living with HIV/AIDS) through age 26, if they did not get fully vaccinated when they were younger.

A clinic utilization rate was selected as an outcome measure based on program throughput rates utilizing current data from the adult pilot project and from our time studies within our immunization clinics. Immunizations are a highly effective evidenced based preventative intervention; however, this project targets populations that experience barriers to accessing preventative health care. As noted earlier, a secondary purpose will be to establish new collaborations with agencies providing social services and support to high-risk populations. With respect to our target populations we chose an outcome measure focused on increasing accessibility to services, as opposed to an ideal compliance of immunization recommendations (i.e. immunization rate). The program also recognizes there are inherent challenges in obtaining valid and reliable outcome data in working with these populations.

Therefore, the program's Category 3 outcome improvement targets are to increase utilizations rate of services, beginning at 24% of clients seeking care in the HHSD STD/HIV clinics for the first year and reaching 30% in year four. This outcome improvement target was reviewed and provisionally accepted by TMF.

Relationship to Other RHP Projects

201320302.2.1 - City of Austin Health & Human Services Department - Provide ACT Model for Participants of HF PSH - This project relates through a potentially similar target population.

List of Related Category 4 Projects

RD-1 Bacterial Pneumonia Immunization
RD-1 Influenza Immunization

Relationship to Other Performing Providers' Projects in the RHP

Through the provision of immunizations to high-risk populations we will reduce the impact to the overall health care system with fewer cases of vaccine preventable diseases realized in the health care region. Other related projects include:

307459301.2.4 - Community Care Collaborative - Sexually Transmitted Disease Screening, Treatment, and Prevention

List of Other Providers in the RHP that are Proposing Similar Projects

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions

continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

Project Valuation

Approach for Valuing Project

This project targets prevention efforts for four antigens: HPV, hepatitis A, influenza and pneumonia in high-risk populations. An analysis of treatment and economic cost estimates for cervical cancer, anal cancer, pneumonia and hepatitis A were used to develop cost estimates. We estimated a utilization rate for each vaccine based on target populations which reduced the total value. For example, of the 3750 total clients to be served, we anticipate providing hepatitis A vaccine to 24%; so we limited the total value for that particular antigen. We then limited the cost avoidance value based on a conservative disease prevention efficacy rate of 2% which yields an estimated avoidance cost of $2,087,657.06.

Rationale/Justification for Valuation

The calculations to value the proposed project are based on a cost avoidance estimate of the potential cost savings for these specific diseases.

UNIQUE PROJECT IDENTIFIER: **201320302**	**RHP PP REFERENCE NUMBER: 201320302.2.6**	***PROJECT COMPONENTS: 2.7.6***	***ADULT IMMUNIZATIONS TO HIGH RISK POPULATIONS***
City of Austin Health & Human Services Department			201320302
Related Category 3 Outcome Measure(s):	201320302.3.8	IT11.1	Improvement in Clinical Indicator in Identified Disparity Group

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X] Hire personnel; obtain medical resources to begin implementing program to target high risk populations which include Medicaid, Medicaid eligible and indigent populations. Metric 1 [P-X.1] Goal: Hire 1 LVN to expand clinic hours Data Source: HR Record Metric 2 [P-X.2] Assess and determine appropriate vaccine formulary for target populations and purchase vaccines. Data Source: Planning meeting minutes and purchase order receipts Metric 3 [P-X.3] Delivery of immunizations to approximately 280 clients per month Data Source: TWICES data base client count Baseline Goal: Provide 280 immunizations to adult high risk clients per month	**Milestone 3** [I-7] Increase access to disease prevention programs using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to disease prevention programs but are not required. Metric 1[I-7.1]: Increased number of encounters a. Total number of encounters at new immunization sites and during expanded hours b. Data Source: Registry, EHR, claims c. Rationale/Evidence: This measures the increased volume of visits Data Source: TWICES data base client count Baseline Goal: Provide 285 immunizations to adult high risk clients per month Milestone 3 Estimated Incentive Payment: $1,916,469	**Milestone 4** [I-7] Increase access to disease prevention programs using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to disease prevention programs but are not required. Metric 1[I-7.1]: Increased number of encounters a. Total number of encounters at new immunization sites and during expanded hours b. Data Source: Registry, EHR, claims c. Rationale/Evidence: This measures the increased volume of visits Data Source: TWICES data base client count Baseline Goal: Provide 291 immunizations to adult high risk clients per month Milestone 4 Estimated Incentive Payment: $1,954,798	**Milestone 5** [I-7] Increase access to disease prevention programs using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to disease prevention programs but are not required. Metric 1[I-7.1]: Increased number of encounters a. Total number of encounters at new immunization sites and during expanded hours b. Data Source: Registry, EHR, claims c. Rationale/Evidence: This measures the increased volume of visits Data Source: TWICES data base client count Baseline Goal: Provide 297 immunizations to adult high risk clients per month Milestone 5 Estimated Incentive Payment: $1,772,350

UNIQUE PROJECT IDENTIFIER: **201320302**	**RHP PP REFERENCE NUMBER: 201320302.2.6**	***PROJECT COMPONENTS: 2.7.6***	***ADULT IMMUNIZATIONS TO HIGH RISK POPULATIONS***
City of Austin Health & Human Services Department			201320302
Related Category 3 Outcome Measure(s):	201320302.3.8	IT11.1	Improvement in Clinical Indicator in Identified Disparity Group

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment: $991,637 **Milestone 2** [I-7] Increase access to disease prevention programs using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to disease prevention programs but are not required. <u>Metric 1[I-7.1]:</u> Increased number of encounters a. Total number of encounters at new immunization sites and during expanded hours b. Data Source: Registry, EHR, claims c. Rationale/Evidence: This measures the increased volume of visits Data Source: TWICES data base client count Milestone 2 Estimated Incentive Payment: $991,637			
Year 2 Estimated Milestone Bundle Amount: $1,983,274	Year 3 Estimated Milestone Bundle Amount: $1,916,469	Year 4 Estimated Milestone Bundle Amount: $1,954,798	Year 5 Estimated Milestone Bundle Amount: $1,772,350
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 7,626,891			

Community Care Collaborative
Category 2 DSRIP Projects

Community Care Collaborative
The Community Care Collaborative's Patient-Centered Medical Home Model
307459301.2.1 – PASS 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the county's Local Mental Health authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will build a "neighborhood" of patient centered medical homes. All of the providers who work with the CCC to deliver care to safety net populations in Travis County will be expected to achieve certain levels of PCMH practice. The primary care clinics that are part of the CCC will be expected to implement the entire medical home model, and to work towards some level of PCMH recognition. As each provider implements the medical home model, there will be opportunities to share best practices across organizations at frequent "townhall" learning collaborative meetings.

Need for the project: The redesign of the local health care delivery services is needed to address the lack of care coordination and prevalence of high cost incidents, including preventable emergency room visits and hospital admissions within the region. Through the adoption of the PCMH model and the implementation of the CCC's 13 other DSRIP projects, critical infrastructure and services will be developed that will allow for better data exchange between hospitals, medical homes, and patients; shared care standards will be implemented; access to care will expanded, and delivered by a patient-focused, multi-disciplinary care team. The CCC will use this Patient Centered Medical Home project as the true building block for its redesign of the indigent care system as it transitions Travis County to accountable, outcome-based care.

Target population:. The CCC's covered population will initially be around 50,000 persons under 200% of the Federal Poverty Level. All of these patients will be affected by the implementation of PCMH model. In addition, all patients who come into contact with the CCC's provider network, regardless of payor, will benefit from more patient-centered care. This includes thousands of low-income uninsured and Medicaid patients.

Category 1 or 2 expected patient benefits: Through this project, we project that in DY3, 10,000 patients will receive care through clinics adopting the PCMH model; in DY4, 12,500 patients will; in DY5, 15,000 patients will. In total, by the end of DY5, 37,500 patients will receive their care through clinics following the CCC's PCMH principles.

Category 3 outcomes:

OD-1- Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

IT-1.13 Diabetes care Foot exam (NQF 0056)

OD-6 Patient Satisfaction

IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores.

Title of Project: The Community Care Collaborative's Patient-Centered Medical Home Model
Project Option: **2.1.4 –** Enhance/Expand Medical Homes "Other" project option: Implement other evidence-based project to enhance/expand medical home in an innovative manner not described in the project options above.
Unique Project ID: 307459301.2.1 – PASS 3
Performing Provider Name: Community Care Collaborative (CCC)
TPI: 307459301

Project Description:
The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and align payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

The Patient Centered Medical Home Project is the centerpiece of the CCC's 14 proposed DSRIP projects. Through the PCMH Project, the CCC will see its entire network of safety net providers adopt core features of patient centered medical homes. All three Federally Qualified Health Center networks – which will together account for 25 clinic sites in Travis County by DY5 – will achieve system-wide 2011 NCQA PCMH accreditation by DY5. Each year, the number affected by implementation of the medical home model will increase, as changes are implemented through the CCC system. Every patient who receives services at one of the safety net providers within the CCC will benefit from this healthcare practice transformation, whether part of the CCC's covered population or not.

The other DSRIP projects are:

- Disease Management Registry
- Chronic Care Management Models
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project

These fourteen DSRIP projects, taken together, will transform how indigent care is delivered in Travis County. The breadth of transformation would not be possible without the adoption of a PCMH model of care delivery, creating a neighborhood of medical homes that reflects how care is delivered within the safety net – by multiple providers in multiple locations. By creating better linkages between providers through the PCMH model, which is then undergirded by shared protocols and an integrated disease management registry, the CCC is building a wellness-focused experience for the patient while it improves coordination and reduces costs.

The goals of the CCC align with those of the PCMH model. As stated at its launch, the CCC's

> "system of care will incorporate new capabilities and services that shift from a focus of treating illness to emphasizing the prevention of illness, management of chronic diseases and the promotion of health. This more effective system will support collaboration among providers, care managers and navigators who will work in partnership with the patient toward a shared goal of improved health. … To accomplish the goals, the new system will have in place appropriate technology that knits together providers, navigators and care managers in multiple locations. This will include a comprehensive patient database and analysis tools that support improved clinical care, patient management and navigation."[64]

This very closely mirrors the principles laid out in the Patient-Centered Primary Collaborative's 2012 report, *Benefits of Implementing the Patient Centered Medical Home: A Review of Cost and Quality Results*:

> "The patient-centered medical home is . . . best described as a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety. It is supported by robust health information technology (health IT), provider payment reform focused on patient outcomes and health system efficiencies, and team-based education and training of the health professions workforce." *(p. 3)*

This report further details the benefits of the model as being in alignment with CCC goals:

> "Data demonstrates that the PCMH improves health outcomes, enhances the patient and provider experience of care, and reduces expensive, unnecessary hospital and emergency department utilization." *(p.3)*

Even as the patient experience and health outcomes improve, the CCC will launch payment reform pilot programs. To explore different payment options, the CCC will have to have strong primary care as its backbone; a culture that supports and rewards continuous improvement; a clear organizational mission and commitment to quality and collaboration. These three elements are also principles of the PCMH model, which is another reason why its implementation is so important to the CCC.

As the DSRIP project is launched, all of the providers with whom the CCC contracts to provide services will be required to implement the core elements of the PCMH model. The three FQHCs that operate in

[64] *http://www.centralhealth.net/file/Community%20Care%20Collaborative%20One%20Page%20Overview.pdf*

Travis County will be expected to apply for accreditation. All providers will be expected to participate in regular town hall meetings to discuss the challenges and opportunities that PCMH implementation presents.

Goals and Relationship to Regional Goals:

Project Goals

The goal of this project is to establish a patient-centered model of care across all safety net providers and to improve the patient experience of care as measured through patient satisfaction surveys. In addition, patient access to care will improve, as demonstrated through a decrease in time to third next available appointments, and an increased rate of annual screenings for certain conditions.

RHP 7 Goals

This project aims to improve the health of CCC patients in Travis County through improved care coordination facilitated by infrastructure enhancements, maximization of health care resources, and improved patient care experiences. This project meets the following regional goals:

- Goal 1: Prepare and develop infrastructure to improve the health of the current and future Region 7 population.
- Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
- Goal 4: Bolster individual and population health by improving chronic disease management.

Challenges & How the Performing Provider Will Address those Challenges:

While some of the safety net providers have moved towards the PCMH model, there will be challenges to full implementation throughout the network as detailed below.

- Varying Degrees of Readiness/Desire for Change. Some providers will require more changes within their practice to adapt to this new model so may be more resistant to this effort.
- Coordination of Care. Providers must be willing to work collaboratively with other providers and other members of the care team on key care decisions for patients.
- Patient Self-Care. Care teams will need to be trained on the best practices for obtaining patient adoption of recommended self-care management standards.

The resolution of each of these issues will be facilitated by two important factors:

- The availability of PCMH implementation guidelines to assist in planning for and addressing these issues.
- The assistance of peers as presented through learning collaboratives and guided training sessions, not just through implementation but also in steady state of practice.

The CCC will make adequate resources available to its providers to ensure that implementing these models goes smoothly. The CCC will support CQI activities both within provider organizations and among provider organizations.

Starting Point/Baseline:

As it has just been launched, the CCC has not promulgated any PCMH standards for its contracted providers. The number of facilities recognized under 2011 PCMH standards in Demonstration Year (DY) 2 is 0.

Rationale

Implementing a village of Patient Centered Medical Homes represents the right choice for the CCC for two reasons: it will improve the care experience & outcomes for the patient, and will lay the foundation for payment reform.

Findings of the RHP7 Community Needs Assessment show that the community is using the most expensive care settings unnecessarily, and that services are being duplicated.

- Lack of Accessible Primary Care: Almost 50% of ED visits in 2011 were for services that could have been provided in a primary care setting. An additional 6% of visits required emergent care that might have been avoided with appropriate ambulatory care.
- Inefficient Use of Resources: Adult residents of RHP 7 have more than 8,500 potentially preventable inpatient hospitalizations per year. These hospitalizations contributed to nearly $1 billion in hospital charges between 2005 and 2010.
- Limited Collaboration and Support Systems: Qualitative regional data indicate a need for better coordination across settings of care. Specific issues include lack of co-located services, separate funding streams, lack of effective IT systems, and providers' historical focus on particular symptoms or disorders.

Through this project, providers will redesign their practice to reduce the system's reliance on these costly and ineffective resources. The PCMH model works to get patients into care when they need it, maximizing access and reducing reliance on expensive points of care and duplicative services.

Further, the CCC will not have a successful ACO-like model without the infrastructure that a neighborhood of medical homes ensures: team-based care with established protocols across multiple points of delivery. This project will build the coordination across providers and the proactive, wellness-focused, patient-centric care that can drive down costs.

Project Components:

There are no required components associated with this project. However, many of the required core components from Project Option 2.1.2 - *Collaborate with an affiliated Patient Centered Medical Home to integrate care management and coordination for shared, high risk patients* - will be adopted, either through this DSRIP project or other CCC DSRIP projects. These core components are:

a) *Improve data exchange between hospitals and affiliated medical home sites;*
   - This is a key component of the PCMH project. The CCC will improve data exchange between all providers who care for CCC patients by building on the current HIE to add real-time availability to clinical data; standardizing terminology and data-management practices; and facilitating the cross-walking of data among all sites. This builds on years several years of work by the local HIE – the Integrated Care Collaborative (ICC) – to establish a repository of administrative data for all safety net providers in the region.

b) *Develop best practice plans to eliminate gaps in the readiness assessment;*
   - The CCC will aid all its providers in assessing and addressing their varied degrees of readiness to implement the PCMH model.

c) *Hiring and training team members to create multidisciplinary teams including social workers, health coaches, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients;*
   - As above, the CCC will help its providers identify staff availability as needed to implement the model. At the same time, as the CCC cares for its patients, it will hire social workers, health coaches, care managers, and nurses to provide care management and navigation for patients.

d) *Implementing a comprehensive, multi-disciplinary intervention to address the needs of the shared, high-risk patients in a culturally-sensitive manner;*

- This will be addressed as the CCC develops its Chronic Care Management Care Models through its DSRIP project 307459301.2.2.

e) *Evaluating the success of interventions at decreasing preventable ED and inpatient hospitalization and improving interventions as necessary;*

- The CCC exists to analyze data from all of its projects, to evaluate the effectiveness of interventions, and to allocate future resources to improve the delivery and function of healthcare in Travis County.

f) *Conducting QI processes such as rapid cycle improvement.*

This will be a required activity for all CCC providers, with leadership from the CCC and its commitment to CQI. The CCC will devote ample resources to CQI, through supporting improvement at the clinic level up to the CCC's operations level.

Unique community need identification numbers the project addresses:

- CN.7 Lack of coordination of care across settings of care, multiple conditions, and physical and behavioral health
- CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

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

This project represents this first great step towards establishment of an indigent care ACO-like model in Central Texas. It will also significantly enhance the collaborative work of CCC providers around HIE, data analytics, and care collaboration.

The current Indigent Care Collaborative HIE system allows for the sharing of patient administrative data among all participating community safety-net providers. While Travis County has benefitted greatly from the work of the ICC, there remain limitations in the existing HIE system that will be resolved and enhanced through this project. Limitations of the current system include –

- The need for providers to log out of their own EHR or other data system to log into the ICC system to access patient data from other providers.
- The limited amount of access to real-time clinical data that could inform the next steps in the care process.
- The need for a higher level of standardization across data systems that would address semantics in text fields, etc. to allow for easier and more accurate reporting.
- An enhanced cross-walking system to allow for greater bi-directionality of data flow.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

As a new initiative, the Community Care Collaborative receives no funds from the US Department of Health and Human Services. One of its founding partners, the Seton Healthcare Family, is a member of the Pioneer ACO project. There is no overlap in patient population, however, between that project and the CCC's covered population. Additionally, both the safety net providers have received federal HITECH funding. Funds through this PCMH project would not duplicate HITECH awards, as the PCMH funds would work to connect multiple systems into a network of data. We are building on existing HIE and connectivity to collate these data in order to turn it into useful information on the health status of our patients and how we can treat them. Finally, FQHCs receive HRSA funding for operations, and one FQHC is receiving funds through CMS' FQHC Advanced Primary Care Practice Demonstration. This pilot, which

will conclude in November 2014, offers the FQHC a monthly care management fee per eligible Medicare beneficiary to implement certain PCMH principles and achieve NCQA Level 3 certification by the end of the project period.

Related Category 3 Outcome Measures:

OD-1- Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

IT-1.13 Diabetes care Foot exam (NQF 0056)

These measures indicate a patient's access (3rd next available) and adherence to quality indicators.

OD-6 Patient Satisfaction

- IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores

This measure helps providers obtain the patient's perspective on care and allows for objective comparisons across institutions and time in areas of importance to consumers.

Relationship to other Projects:

This PCMH project is inextricably linked to the thirteen other CCC projects listed on page 1. It forms the spine of the new indigent healthcare system that is being launched in Travis County, but all projects are part of this fully integrated system, and each makes sense as part of a larger whole.

Relationship to Other Performing Providers' Projects

The PCMH project relates to other patient-focused care programs being proposed for Travis County, including: 121789503.1.1, Expanding Primary Care Capacity for Low-Income Residents of Hays County, TX, a Pass 1 project submitted by Central Texas Medical Center. This project also is related to many of projects in Region 7 where chronic disease interventions may take place in the PCMH. Projects include:

186599001.2.1: Family and Child Obesity
137265806.2.6: Chronic Care Management: Adults
137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative:

RHP 7 DSRIP participants recognize the importance of learning from each other's implementation experiences and will create regular opportunities to share ideas and solve problems, including bi-annual, region-wide meetings, conference calls, on-going use and updating of the RHP 7 website, and smaller, topical meetings as needed to share information, updates and best practices. This multi-pronged approach will allow for continuous improvement of regional projects, which will in turn better serve RHP 7's population and transform its healthcare delivery system.

Within the CCC, Learning Collaboratives will play a large role as continuous a means to spread best practices and share innovations. These frequent meetings will serve as reinforcement for providers who are implementing the practice changes and help

Project Valuation:

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

UNIQUE IDENTIFIER: *307459301.2.1*	***RHP PP REFERENCE NUMBER*** *2.1.4*	***PROJECT COMPONENTS:*** *N/A*	***PROJECT TITLE:*** *THE COMMUNITY CARE COLLABORATIVE'S PATIENT-CENTERED MEDICAL HOME MODEL*	
Performing Provider Name: Community Care Collaborative				*TPI:* 307459301
Related Category 3 Outcome Measure(s):	*307459301.3.13*	IT-6.1	Percent Improvement over Baseline of Patient Satisfaction Scores	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-8]: Develop or utilize evidence based training materials for medical homes based upon the model change concepts. Metric 1 [P-8.1]: Documentation of staff training materials. Data Source: Training materials Milestone 1 Estimated Incentive Payment : $1,265,901 **Milestone 2** [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: 1 in DY2 due to shortened operations period Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes Milestone 2 Estimated Incentive Payment : $1,265,901	**Milestone** 5 [P-1]: Implement the medical home model in primary care clinics. Metric 1 [P-1.1]: Increase number of primary care clinics using medical home model Goal: 25% of Community Care Collaborative Providers will use CCC medical home model Data Source: Performing Provider Data Metric 2 [P-X]: Increase number of patients receiving services from clinics using CCC's medical home principles 10,000 patients will receive services under this model Data Source: Performing Provider Data; EHR Milestone 5 Estimated Incentive Payment: $1,558,933		**Milestone 8** [P-1]: Implement the medical home model in primary care clinics. Metric 1 [P-1.1]: Increase number of primary care clinics using medical home model Goal: 75% of Community Care Collaborative Providers will use medical home model Data Source: Performing Provider Data Metric 2 [P-X]: Increase number of patients receiving services from clinics using CCC's medical home principles 12,500 patients will receive services under this model Data Source: Performing Provider Data; EHR Milestone 8 Estimated Incentive Payment: $1,523,770	**Milestone 11** [P-1]: Implement the medical home model in primary care clinics. Metric 1 [P-1.1]: Increase number of primary care clinics using medical home model Goal: 100% of Community Care Collaborative Providers will use medical home model Data Source: Performing Provider Data Metric 2 [P-X]: Increase number of patients receiving services from clinics using CCC's medical home principles 15,000 patients will receive services under this model Data Source: Performing Provider Data; EHR Milestone **11** Estimated Incentive Payment: $1,230,737

Table continues on page 579

Milestone 3 [P-X]: Complete a planning process to design the transition plan to implement a PCMH model of care for the CCC provider network Metric 1 [P-14.1]: Planning Process Data Source: Plan Document Milestone 3 Estimated Incentive Payment: $1,265,901 **Milestone 4 [P-X]:** Designate/hire personnel or teams to support and/or manage the project/intervention Metric 1: Team in charge of developing and managing project & supporting efforts Goal: Identify and hire a team. Data Source: HR records Milestone 4 Payment: $1,265,901	**Milestone** 6 [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: 2 per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes Milestone 6 Estimated Incentive Payment: $1,558,934 **Milestone 7** [P-X]: Incorporate Patient Experience Surveying Metric 1: Medical home recognition/accreditation. Goal: Develop, test & implement systems to incorporate patient experience surveys into care provision Data Source: Patient Surveys; Guidelines for providers Milestone 7 Estimated Incentive Payment: $1,558,934	**Milestone 9** [I-18]: Obtain medical home recognition by a nationally recognized agency Metric 1 [I-18.1]: Medical home recognition/accreditation. Goal: 33% of FQHCs will be recognized Data Source: Documentation of recognition/accreditation Milestone 9 Estimated Incentive Payment: $1,523,770 **Milestone 10** [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: 2 per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes Milestone 10 Estimated Incentive Payment $1,523,669	**Milestone 12** [I-18]: Obtain medical home recognition by a nationally recognized agency Metric 1 [I-18-1]: Medical home recognition/accreditation. Goal: 100% of FQHCs will be recognized Data Source: Documentation of recognition/accreditation Milestone **12** Estimated Incentive Payment: $1,230,737 **Milestone 13** [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: 2 per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentation, and/or meeting notes Milestone **13** Estimated Incentive Payment: $1,230,737
Year 2 Estimated Milestone Bundle Amount: $5,063,604	Year 3 Estimated Milestone Bundle Amount: $4,676,801	Year 4 Estimated Milestone Bundle Amount: $4,571,309	Year 5 Estimated Milestone Bundle Amount: $3,692,211
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $18,003,925**			

Community Care Collaborative
The Community Care Collaborative's Multiple Chronic Disease Management Model
307459301.2.2 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in April 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will research, design and implement Chronic Care Management models to be used across its network of safety net providers. These models will define the clinical protocols, care team staffing, and patient self-management guidelines for the CCC's 18,000 patients with Multiple Chronic Conditions. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this DSRIP will lead to better clinical outcomes for the patient, less reliance on acute and emergency care, and lowered costs of care for the indigent care system in Travis County.

Need for the project: What the CDC has said about the United States is true about Travis County: Chronic diseases are among the most common, costly, and preventable of all health problems here. However, current safety-net health care is fragmented among numerous providers that do not operate under a single standard of care and do not have access to an efficient, shared patient data exchange. This unconnected "system" impedes timely information sharing, best practice implementation, and tracking of the total healthcare-related services received by a particular patient.

Target population: All care providers within the CCC network will be expected to implement the Chronic Care Management Models. Of the 50,000 patients at or below 200% of FPL that the CCC expects to cover initially, an estimated 18,000 have multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes. The positive impact of the models will not be limited to the CCC's covered population, however; all patients who come into contact with the CCC's provider network, regardless of payor, will benefit from the evidence-based care guidelines and team care approach. This includes thousands of low-income uninsured and Medicaid patients.

Category 1 or 2 expected patient benefits: The project seeks to enroll at 12,000 patients with Multiple Chronic Conditions (MCCs) in the new care model by DY5.

Category 3 outcomes:
Outcome Domain 1, Primary Care and Chronic Disease Management

- IT-1.6 Cholesterol management for patients with cardiovascular conditions
- IT-1.11 Diabetes care: BP control (<140/90mm Hg)

Title of Project: Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions
Category / Project Area / Project Option: 2.2.1

RHP Project Identification Number: 307459301.2.2

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459201

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

The Chronic Care Management Project will result in better health outcomes for the 12,000 patients with Multiple Chronic Conditions who are enrolled through DY5 and who will receive evidenced-based, multi-disciplinary care that is standardized across of the CCC's providers. There are an estimated 18,000 of these very sick persons in the CCC's population with two or more of the following conditions: heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes. These patients will benefit from a robust care protocol as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project

The CCC's Chronic Care Management Model will be comprised of:

- *Clinical guidelines* that define standards of care for the assessment, diagnosis, treatment, and pharmacological management for the chronically ill in the CCC. These clinical guidelines will be based on evidence-based best practices, and will be updated accordingly in a process of continuous improvement and refinement.
- *Care team guidelines* that define the composition, function, and tasks of the CCC's Chronic Disease Care Teams. These guidelines will describe the composition of patient care teams and lay out the CCC's approach to ensure effective clinical, pharmacological, nutritional, educational and psychosocial interventions reach the patients who need them. These care team guidelines will emphasize patient-centeredness and culturally and linguistically appropriate care.
- *Education and Self-Management Guidelines* that emphasize increasing patient capacity for self-care through knowledge expansion and behavior change.

As Wagner noted over fifteen years ago, patients with chronic illness have complex needs:

> "[The chronically ill] require planned, regular interactions with their caregivers, with a focus on function and prevention of exacerbations and complications. This interaction includes systematic assessments, attention to treatment guidelines, and behaviorally sophisticated support for the patient's role as self-manager. These interactions must be linked through time by clinically relevant information systems and continuing follow-up initiated by the medical practice."
> (Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract*. 1998 Aug-Sep;1(1):2-4.)

These needs are not currently being met by the safety net system. This DSRIP Project, along with the other CCC DSRIP projects proposed, will give CCC care teams the tools to deliver the right care in the right place.

Patients will be identified as eligible for services through the protocol at many points of care: by their providers; at enrollment into the CCC; at acute or Emergency Departments; and at social services agencies. Multi-disciplinary care teams, staffed by navigators, social workers, nurses and physicians, will provide responsive care with an emphasis on follow-up and also self-management. Patients will be asked to report on their own perceptions of functional status through the in-development Multiple Chronic Conditions Functional Status Assessment, which will be integrated into the EHR and administered annually.

Project Goals

The CCC's Chronic Care Management Model project will:

- Design Clinical Care, Care Team, and Education & Self-Management Guidelines for the CCC population with multiple chronic conditions;

- Train members of the provider network in operating under the Guidelines;
- Implement the Model and consistently improve its operation and design using CQI principles;
- Enroll at least 12,000 patients in the appropriate model by DY5;
- Result in improved clinical outcomes for the target population.

Challenges or Issues Faced by the Performing Provider

Because this DSRIP project is proposing that the CCC reconfigure the safety net system to address the needs of patients with multiple chronic diseases, a number of potential obstacles will likely be encountered, including:

- Obtaining the commitment to change and continued willingness to learn from multiple providers across multiple-sized health care organizations;
- Identifying protocols that can be agreed-upon by all entities and that support care for individuals with multiple chronic diseases;
- Ensuring that any protocols and guidelines developed can be absorbed into provider care team work flow; and
- Translating patient education materials into all linguistically and culturally appropriate methods for best transmission and understanding.

How the Project Addresses those Challenges

A challenge-free systems change may not be achievable, but several steps will be taken to aid the transition to the new management model. The CCC's leaders and provider physicians will be recruited to become champions of the change, offering visible support for adoption of the new model. This will be reinforced by the CCC's move to quality-linked payments, through which incentives will be based on quality of care, and shared savings models. Additionally, the CCC will be guided by a panel of physician-leaders that reports to the CCC's Board.

The challenge of drawing up a set of interventions that address patients with multiple conditions will be addressed through a process of continuous engagement and improvement with provider care teams. This complex model will be developed by a dedicated team hired specially for this purpose, and advised by the CCC clinical leadership team that will establish a best practice model of clinical protocols that includes coordination and navigation of patient care.

On-going shared learning opportunities throughout the implementation of the model will also facilitate the transition.

How the Project is Related to RHP Goals

This DSRIP project is related to five of RHP 7's goals:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
3. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
4. Bolster individual and population health by improving chronic disease management.
5. Support prevention education and healthy lifestyles to improve population health.
7. Improve the patient experience of care by increasing the quality of care and patient safety.

Starting Point/Baseline

There is no standardized Chronic Care Management Model currently used across Travis County's safety net provider system for individuals with one or multiple chronic conditions. Thus, the number of providers using the model is 0 and the number of patients receiving care under the model is also 0.

Rationale

Reason for Selection of Project Options and Components

Chronic diseases are the most common, costly, and preventable of all health problems in the county. Because these diseases are slow to progress and because the CCC serves medically-indigent individuals, many of whom have been out-of-care for many years, a high percentage of the CCC's patient population suffer from one or more chronic diseases. As the Region 7 Community Needs Assessment reports –

> Patients with multiple chronic conditions have a higher risk of potentially preventable hospitalizations, contribute to higher healthcare costs, and are a greater challenge for coordination of care. Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition. (pg. 13)

Chronic diseases are characterized by gradually worsening symptoms that often do not manifest themselves until they are somewhat progressed. Once diagnosed, these diseases must be managed by the patient through changes in daily activities. Individuals who do not see a provider on a regular basis, however, are more likely to be unaware of their condition and thus uneducated on the changes they need to make. They do not receive reminders for necessary follow-up assessments or receive "check-ins" by members of a care team who can help them remember to take their medications, assess their blood sugar levels, etc., or make referrals to specialty providers and/or other support services to help ensure that they can successfully care for themselves.

As required, the following components will be implemented:

a) *Design and implement care teams that are tailored to the patient's health care needs.* The composition of these teams will be detailed in the CCC's Care Team Protocols as will the standards for best places/modes for patient engagement, and guidelines for linguistic and cultural sensitivity.
b) *Ensure that patients can access their care teams in person or by phone or email.* The Care Team Protocols will include new standards for increasing patient access to care teams, including web-based patient portals. As a number of the CCC's providers continue to develop their electronic systems to conform to Meaningful Use standards, they will be able to share their experiences with others.
c) *Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources.* The CCC will codify its expectations for patient engagement in its Education and Self-Management Guidelines, which will detail roles for all levels of delivery system stakeholders to achieve maximum levels of patient engagement.
d) *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.* Chronic Disease Self-Management best practice projects will be identified and implemented in accordance with the Education and Self-Management guidelines. Such projects may include peer

supported trainings; community health worker facilitated workshops; and other evidence-based practices.

e) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.* The Chronic Care Management Protocols will be living documents, subject to scrutiny and capable of evolution. Feedback from all stakeholders will be welcome, and the protocols will be constantly evaluated in terms of their ability to improve the patient experience, achieve better clinical outcomes, and lower costs. These evaluation activities will be conducted on an ongoing basis through the CCC's analytics unit, and its Clinical Leadership team, and also through its performance improvement activities.

Unique Community Need Identification Number

- CN.7 Lack of coordination of care across: Settings of care, multiple conditions, physical and behavioral health
- CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions
- CN.9 High rates of chronic disease such as: Cardiovascular disease, cancer, & rising rates of diabetes
- CN.10 Many residents in Region 7 have multiple chronic conditions

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

The Community Care Collaborative is a new delivery system reform initiative for all indigent populations under 200% of FPL living in Travis County. All of the projects represent large-scale attempts to transform the way care delivery system.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

The Community Care Collaborative receives no funds from the US Department of Health and Human Services.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

- IT-1.6: Cholesterol Management
- IT-1.11: Blood pressure

Reasons/Rationale for Selecting the Outcome Measure(s)

- High blood pressure is a clinical problem for many patients with Chronic Conditions.
- Managing cholesterol will be a key indicator of success of management of heart disease and other health problems related to obesity.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This Chronic Care Management Model Project will go hand-in-hand with two other CCC projects to build critical infrastructure and redesign care for the CCC's target population. The other two CCC' projects are

the PCMH Project (307459301.2.1) and its Disease Management Registry project (307459301.1.1) All three projects lay the groundwork to enhanced, patient-centered care for CCC's the complexly ill patients. The PCMH project will enable real time clinical data exchange between PCMH-focused providers and hospitals; while the Disease Management Registry project will build analytics capability to inform refinement of treatment approaches such as appear in the Protocols.

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-1.2. Diabetes Admission Rates
RD-1.4 Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
RD-1.5 Hypertension Admission Rate
RD-2.2 Diabetes: 30-Day Readmissions
RD-2.5 Stroke: 30-Day Readmissions
RD-2.7 All-Cause: 30-Day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects
This project relates most closely to other RHP 7 efforts to enhance services for Travis County indigent adult patients that have complex medical conditions.

133542405.2.5: Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults
201320302.2.2 Expansion of Community Diabetes Project
137265806.2.5: Care Transitions
137265806.2.6: Chronic Care Management: Adults
137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach for Valuing Project

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Institute for Healthcare Improvement's Triple Aim framework, supported the 1115 DSRIP Waiver goals and addressed identified community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

UNIQUE IDENTIFIER: 307459301.2.2	***RHP PP REFERENCE NUMBER: 2.2.1***	***PROJECT COMPONENTS: 2.2.1 A-E***	***PROJECT TITLE: EXPAND CHRONIC CARE MANAGEMENT MODELS: THE COMMUNITY CARE COLLABORATIVE'S MULTIPLE CHRONIC DISEASE MANAGEMENT PROTOCOL***	
Community Care Collaborative				*TPI: 307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.14* *307459301.3.15* *307459301.3.16*	*IT-1.6* *IT-1.11*	*Cholesterol Management* *Blood Pressure Control*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Designate/hire personnel or teams to support and/or manage the project/intervention Metric 1 [P-X.1]: 1 Designated Team Data Source: HR Records/Team List Goal: Developing major clinical protocols that are (a) evidenced-based; (b) incorporate best practices that are already in use by the CCC's constellation of safety providers; (c) respond to the complex needs of the sickest low-income un- and underinsured patients in Travis County; (d) will be implemented across a number of practices of different size and scope will be a challenge. It will need to be managed by a small team of professionals who can synthesize all of the available information into a series of documents, roll out the intervention, and support its implementation. Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,631,158 **Milestone 2** [P-X]: Complete a	**Milestone 3** [P-3] Develop a comprehensive care management program. <u>Metric 1</u> [P-3.1] Documentation of Care management program. Goal: Publish and implement an evidenced-based comprehensive care management program for patients with multiple chronic conditions within the CCC that includes protocols and guidelines for clinical practice; patient self-management; standing orders; group and telephone visits; how to identify patients in need of services; and other elements. Data Source: Program materials. Milestone 3 Estimated Incentive Payment: $2,430,167 **Milestone 4** [P-4]: Formalize multi-disciplinary teams, pursuant to the Chronic Care Model <u>Metric 1</u> [P-4.1]: CCC contracted sites with in-place or access to	**Milestone 5** [P-4]: Formalize multi-disciplinary teams, pursuant to the Chronic Care Model. <u>Metric 1</u> [P-4.1]: Goal: 100% of CCC sites have their own multi-disciplinary teams or participate in multidisciplinary teams. At the same time that these multi-disciplinary teams are formed, CCC providers will be trained in the new MCC care management protocols. Data Source: CCC records Milestone 5 Estimated Incentive Payment: $1,583,588 **Milestone 6** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally <u>Metric 1</u> [I-17.1]: Patients with MCCs enrolled in the care management model Goal: Enroll 5,000 patients Data Source: Registry Milestone 6 Estimated Incentive	**Milestone 8** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally <u>Metric 1</u> [I-17.1]: Patients with MCCs enrolled in the care management model Goal: Enroll 7,000 patients Data Source: Registry Milestone 8 Estimated Incentive Payment: $1,918,553 **Milestone 9** [P-X]: Incorporate continuous learning to improve Protocols & Provider Performance <u>Metric 1</u> [P-X.1]: Evaluate intervention, and implementation modify intervention as appropriate, develop policies & procedures, and share lessons learned Data Source: Communications; Revised program materials. Milestone 9 Estimated Incentive Payment: $1,918,553

UNIQUE IDENTIFIER: 307459301.2.2	***RHP PP REFERENCE NUMBER: 2.2.1***	***PROJECT COMPONENTS: 2.2.1 A-E***	***PROJECT TITLE: EXPAND CHRONIC CARE MANAGEMENT MODELS: THE COMMUNITY CARE COLLABORATIVE'S MULTIPLE CHRONIC DISEASE MANAGEMENT PROTOCOL***	
Community Care Collaborative				*TPI: 307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.14* *307459301.3.15* *307459301.3.16*	*IT-1.6* *IT-1.11*	*Cholesterol Management* *Blood Pressure Control*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign Metric 1 [P-X.1]: Provide Care Management Model Development, Implementation and Enrollment Plan Detailing the following: • Existing practices within CCC • Population Analysis • Best Practices, Locally and Nationally • Gaps in Services • Suggestions for Model Development • Implementation Outline • Enrollment Projections & Strategies • Identified Barriers & Ways to Overcome Barriers Goal: Produce Plan that details the steps and resources needed to develop and launch the Chronic Care Model and achieve the stated outcomes.	multidisciplinary teams Goal: 50% of CCC sites have their own multi-disciplinary teams or participate in multidisciplinary teams. At the same time that these multi-disciplinary teams are formed, CCC providers will be trained in the new MCC care management protocols. Data Source: CCC records Milestone 4 Estimated Incentive Payment: $2,430,167	Payment: $1,587,567 **Milestone 7** [P-X]: Incorporate continuous learning to improve Protocols & Provider Performance Metric 1 [P-X.1]: Evaluate intervention, and implementation modify intervention as appropriate, develop policies & procedures, and share lessons learned Data Source: Communications; Revised program materials. Milestone 8 Estimated Incentive Payment: $1,583,567	

UNIQUE IDENTIFIER: 307459301.2.2	***RHP PP REFERENCE NUMBER: 2.2.1***	***PROJECT COMPONENTS: 2.2.1 A-E***	***PROJECT TITLE: EXPAND CHRONIC CARE MANAGEMENT MODELS: THE COMMUNITY CARE COLLABORATIVE'S MULTIPLE CHRONIC DISEASE MANAGEMENT PROTOCOL***
Community Care Collaborative			*TPI: 307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.14* *307459301.3.15* *307459301.3.16*	*IT-1.6* *IT-1.11*	*Cholesterol Management* *Blood Pressure Control*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,631,158			
Year 2 Estimated Milestone Bundle Amount:: $5,262,316	Year 3 Estimated Milestone Bundle Amount: $4,860,334	Year 4 Estimated Milestone Bundle Amount: $4,750,702	Year 5 Estimated Milestone Bundle Amount: $3,837,106
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $18,710,458			

Community Care Collaborative
Integrated Behavioral Health Intervention for Chronic Disease Management
307459301.2.3 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in April 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will develop a care management approach specific to individuals dually diagnosed with diabetes and clinical depression. A care team will help these patients address and manage their dual diagnoses by first providing treatment for their depression. Patients will interact regularly with a care manager, and the care team will engage in a physician-led weekly case review. Patient progress also will be tracked via a disease management registry. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this DSRIP will lead to better clinical outcomes for the patient, less reliance on acute and emergency care, and lowered costs of care for the indigent care system in Travis County.

Need for the project: Depression was the most prevalent mental health condition among low-income Travis County residents and when a co-occurring medical condition was observed, diabetes was one of the medical conditions observed. Indeed, depression is twice as prevalent among persons with diabetes than it is among persons without diabetes. The undiagnosed and untreated presence of depression significantly worsens the outcome or prognosis of a variety of illnesses and disease and increases the annual cost of care by 33% (Petterson, S.M., Phillips, R.L., Basemore, A.L., et al. (2008). "Why there must be room for mental health in the medical home", American Family Physician, 77(6): 757).

Target population: The CCC's covered population will initially be around 50,000 persons under 200% of the Federal Poverty Level. All of these patients will be affected by the implementation of PCMH model. In addition, all patients who come into contact with the CCC's provider network, regardless of payor, will benefit from more patient-centered care. This includes thousands of low-income uninsured and Medicaid patients. This project specifically targets CCC patients who are dually diagnosed with diabetes and depression.

Category 1 or 2 expected patient benefits: This project will provide integrated treatment for approximately 1,500 CCC patients dually diagnosed with diabetes and clinical depression. Using a care-team approach, patients are expected to have improvements on clinical depression and diabetes measures.

Category 3 outcomes:
Outcome Domain 1, Primary Care and Chronic Disease Management

- IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710)
- IT-1.10 Diabetes Care: HbA1c Poor Control (>9.0%) – NQF 0059

Title of Project: Integrated Behavioral Health Intervention for Chronic Disease Management

Project Option: 2.19.1 Innovation and Redesign/Develop Care Management Function that integrates primary and behavioral health needs of individuals/Design, implement, and evaluate care management programs and that integrate primary and behavioral health needs of individual patients
RHP Project Identification Number: 307459301.2.3 Pass 3
Performing Provider Name: Community Care Collaborative
Performing Provider TPI: 307459301

Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

The Integrated Behavioral Health Intervention for Chronic Disease Management Project will provide integrated treatment for approximately 1,000 patients with co-occurring clinical depression and diabetes**.** This project aims to improve these patients' dual diagnoses by implementing integrated care practices to treat these two diseases. These patients will benefit from a robust care protocol as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinic
- Telepsychiatry in Community Clinics
- Pregnancy Prevention
- Community Paramedic Navigator Project
- STD & HIV Screening and Treatment & Referrals

This project uses a care team consisting of a primary care physician, mental health providers, and a care manager to provide care management to a targeted population of patients with co-occurring clinical depression and diabetes; one of the target population for the Community Care Collaborative. In this project, patients will receive treatment for their depression. Successful control and treatment of chronic conditions like diabetes requires major lifestyles changes and often involves adherence to complicated medical regimens. When a patient is depressed, effecting such health changes and maintaining treatment compliance can be even more difficult.

Patients with diabetes will be referred to a behavioral health specialist who will assess the person for clinical depression. Those also diagnosed with clinical depression will receive a treatment protocol specifically designed for co-occurring diabetes and mental health conditions. It is expected that patients who are able to properly manage their depression through therapy and learn self-care skills are able to better control their diabetes. Patients will interact regularly with their care manager either in-person through the patient's medical home, or via telephone conferencing. While the patient interacts with only the care manager on a regular basis, the entire care team plays an integral part in the patient's care via regular case reviews and physician monitoring of the patient's health. Patients will have access to specialty care as needed. To keep track of patients' health through the program and to make changes to patient care as needed, their clinical measurements will be assessed regularly and entered into a disease management registry.

Project Goals

- By the end of 5 years, this project aims to provide services to approximately 1,500 patients dually diagnosed with clinical depression and diabetes
- Patients will receive support to increase medical compliance, improve health outcomes, and increase their self-reported quality of life.
- By the end of 5 years, approximately 30% of program participants are expected to demonstrate depression management at 12 months post-intervention.
- By the end of 5 years, approximately 20% of program participants are expected to demonstrate improved HbA1c control post-intervention.

Challenges or Issues Faced by the Performing Provider

The performing provider acknowledges some of the challenges associated with implementing this project such as clinicians in the primary care setting with training in identifying depression, and behavioral health clinicians with specific training in treating depression. An additional challenge is ensuring consistent implementation of the program across all of its different network providers.

How the Project Addresses those Challenges

Clinicians in this program will have the opportunity to receive training on Mental Health First Aid; part of the curriculum is learning how to identify depression. To address the experience and skills of behavioral health providers, if additional providers are needed, only those with experience or training in evidence-based behavioral strategies such as motivational interviewing, behavioral activation, and systematic problem-solving will be hired. Care team members will be hired with competitive salaries to ensure that access to providers does not limit success in the program.

The CCC will use the learning collaborative as a forum to discuss program implementation and outcomes. These regular meetings will help ensure consistency in program implementation across sites and providers.

How the Project is Related to RHP Goals
The project aligns with the following RHP Goals:

Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
Goal 4: Bolster individual and population health by improving chronic disease management.
Goal 6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crises services and promotes recovery.
Goal 7: Improves the patient experience of care by increasing the quality of care and patient safety.

Starting Point/Baseline

Baseline Data
This is a new program for the CCC; no one is enrolled in this program.

Time Period for Baseline
N/A

Rationale

Reason for Selection of Project Options and Components
Depression was the most prevalent mental health condition among low-income Travis County residents and when a co-occurring medical condition was observed, diabetes was one of the co-occurring medical conditions observed (Region 7 Community Needs Assessment). Indeed, depression is twice as prevalent among persons with diabetes than it is among persons without diabetes (Anderson et al, The prevalence of comorbid depression in adults with diabetes: a meta-analysis. Diabetes Care. 2001 Jun;24(6):1069-78). The undiagnosed and untreated presence of depression both increases the risk of developing certain chronic conditions, such as diabetes, as well as significantly worsening the outcome or the prognosis of a variety of illnesses and diseases. However, the treatment of depression appears to be associated with improved glycemic control (Lustman, P., Freedland, K., Griffith, L.S., & Clouse, R.E. (1998), "Predicting response to cognitive behavior therapy of depression in type 2 diabetes". General Hospital Psychiatry, Sep 20(5):302-6).

Furthermore, there is an economic impact of co-morbidity; the cost of unmet care for individuals with diabetes increases from $4,172 annual for those without a mental health condition, to $5,559 annual for those with a mental health condition; a 33% annual increase in cost (Petterson, S.M., Phillips, R.L., Bazemore, A.W., et al. (2008), "Why there must be room for mental health in the medical home". American Family Physician, Mar 15;77(6):757).

Research indicates that collaborative care between behavioral and medical practitioners, combined with a brief, focused model of intervention to assist with adherence to prescribed medication regimens, results in significantly improved outcomes for patients with depression, diabetes and coronary heart disease (Katon, Lin, et al., (2012). Collaborative care for patients with depression and chronic illnesses. New England Journal of Medicine, 363(27)).

Reasons/Rationale for Selecting the Outcome Measures

Since this is a new project for the CCC, the initial years of the program will focus on project planning, including reviewing chronic care management best practices for treating co-occurring diabetes and depression in the literature, from local network of providers (2.19.1.b) and developing the practice model, and identifying and hiring care managers (2.19.1.c) who will oversee the care management of the target population. An evaluation of promising practice models for diabetes and clinical depression (2.19.1.e) will help the project team to develop the protocols for coordinating care, including identifying community resources to support positive outcomes (2.19.1.d) and to train hired staff on the protocols (2.19.1.f). The protocols and practices developed in this project will fold into and help inform the larger CCC Chronic Care Management Model Protocol project which addresses a larger number of patients with a greater diversity of chronic disease diagnoses.

The target population will be identified based on referral by primary care physicians (PCP). Individuals diagnosed with diabetes will be immediately referred to the behavioral health counselor who will administer the depression inventory (PHQ-9). Individuals scoring high on the depression inventory (a score higher than 9 on the PHQ-9) will make up the cohort; a data match (2.19.1.a) will not be used. This approach minimizes the complexities of identifying and tracking down patients for inclusion in the program. The recruiting process to be used for this program takes advantage of the patient already being present for care with the primary care physician. The initial years of the program will be used to refine the recruiting process.

This project is a longitudinal project that will track program participants over time for several years. Eventually, patient data will be captured in the CCC's Disease Management Registry project but prior to its rollout, DY2 will be used to establish methods of tracking patient data over time 2.19.1(g).

Project developers, along with practitioners will engage in a continuous learning collaborative to review the program's impact on quality of care, integration of care, and identify "lessons learned" to improve the program and to determine feasibility of expanding the project to a larger number of people (2.19.1.h).

Reason for Selection of Milestones/Metrics

The milestones and metrics were chosen because they best represent the sequence of effective project implementation. Demonstration Years 2 and 3 focus on program planning and development to ensure that the best care management protocols are identified and properly implemented so that by the end of DY3, the first set of program participants will begin receiving integrated care for their co-occurring diabetes and depression. By DY4, an even larger number of patients are expected to be included in the program.

Unique Community Need Identification Number

CN.4 Inadequate access to behavioral health care

CN.6 Inadequate services throughout the continuum of care for individuals with behavioral health issues such as screening, outpatient treatment, and integrated care

CN.7 Lack of coordination of care across: settings of care, multiple conditions, physical and behavioral health

CN.9 High rates of chronic disease such as cardiovascular disease, and rising rates of diabetes

CN.10 Many residents in Region 7 have multiple chronic conditions

CN.15 Additive and costly impact of co-occurring mental health, substance use, and medical conditions

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

This project is a new initiative for the performing provider. While providers in the network do engage in integrated care, this project specifically focuses on individuals with clinical depression and diabetes. This program uses a unique pathway to improve a chronic physical health condition via depression management.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-1: Primary Care and Chronic Disease Management
1) IT – 1.9 Depression management: Depression Remission at Twelve Months
2) IT – 1.10 Diabetes Care: HbA1c poor control (>9.0%)

Reasons/Rationale for Selecting the Outcome Measure(s)
These outcomes were chosen because they reflect the outcomes that the project is aiming to achieve. This project aims to identify individuals dually diagnosed with depression and diabetes, and to develop a care plan that manages their depression and diabetes with the goal of improving outcomes in both diseases. Specifically, through interactions with the care manager, who will help ensure the patient has continued access to behavioral health care, improvements in depressive symptoms are expected overtime, which will consequently improve the patient's self-care of the chronic physical disease (diabetes). The improved self-care for diabetes are expected to be reflected in lower blood pressure readings over time.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's 14 projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients are outlined below.

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*

307459301.2.1: Primary Care Medical Home
307459301.1.1: Disease Management Registry
307459301.2.2: Chronic Care Management Model
307459301.1.8: Telepsychiatric Services in Federally Qualified Primary Health Clinic
137265806.1.1: Psychiatric Emergency Department
137265806.2.4: Behavioral Health Navigation
307459301.1.3: Mobile Primary Care

List of Related Category 4 Projects *(RHP Project ID Number)*

RD-1.2 Potentially Preventable Admissions – Diabetes Admission Rate
RD-1.3 Potentially Preventable Admissions – Behavioral Health and Substance Abuse Admission Rate
RD-2.2 30-Day Readmissions – Diabetes: 30-Day Readmissions
RD-2.3 30-Day Readmissions – Behavioral Health and Substance Abuse: 30-Day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

133542405.2.1: Integrate Primary and Behavioral Health Care Services
133542405.2.5: Implementation of Chronic Disease Prevention/ Management Models
126844305.2.4: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County
186599001.2.2: Chronic Care Management – Pediatrics
133340307.2.1: Hays County Mental Health Center Integrated Care
201320302.2.2: Expansion of Community Diabetes Project
137265806.2.4: Behavioral Health Assessment and Resource Navigation
137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year. As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaborative - smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach for Valuing Project

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.2.3	*2.19.1*	**2.19.1.B** **2.19.1.C** **2.19.1.D** **2.19.1.E** **2.19.1.F** **2.19.1.H**	**TITLE:** *Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients*
***Performing Provider Name**: Community Care Collaborative*			***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.17* *307459301.3.18*	*1.9* *1.10*	*Depression Management: Depression Remission at Twelve Months* *Diabetic Care: HbA1c poor control*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-6] - Care coordination protocols are developed Metric: Written protocols are established and available to staff Goal: Complete written protocols Data Source: Written protocols Milestone 1 Estimated Incentive Payment: $1,368,065 **Milestone 2 [P-X] - Designate/hire personnel to support and manage the project** Metric: Human resources contract with personnel Goal: Hire or designate 1 person to support and manage the project. Data Source: Human resources records	**Milestone 3 [P-5] – Behavioral Health case managers and disease care managers are identified.** Metric 3 *[RHP Metric –P5.1]:* Number of staff identified with the capacity to support the targeted population Goal: Identify and/or hire behavioral health providers to support the project implementation, per assessment of need. Data Source: Staff rosters and documents of caseloads Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 842,374 **Milestone 4 [P-18] - Identify target patient population with depression and diabetes to be entered into the registry** Metric: Document patients to be	**Milestone 6 [P-18] - Identify target patient population with depression and diabetes to be entered into the registry** Metric: Document patients to be entered into the registry Goal: 500 patients are identified, entered into the registry, and enrolled in the intervention Data Source: EHR Milestone 6 Estimated Incentive Payment $ 823,372 **Milestone 7 [I-25] - Identify patients with depression and diabetes entered into registry who receive instructions appropriate for their chronic disease according to health intervention care protocols.** Goal: 500 patients with diabetes and depression receive instructions	**Milestone 9 [P-18] - Identify target patient population with depression and diabetes to be entered into the registry** Metric: Document patients to be entered into the registry Goal: 700 patients are identified, entered into the registry, and enrolled in the intervention Milestone 9 Estimated Incentive Payment $ 823,372 **Milestone 10 [I-25] - Identify patients with depression and diabetes entered into registry who receive instructions appropriate for their chronic disease according to health intervention care protocols.** Goal: 700 patients with diabetes and depression receive instructions according to the health intervention care protocols.

307459301.2.3	*2.19.1*	**2.19.1.B** **2.19.1.C** **2.19.1.D** **2.19.1.E** **2.19.1.F** **2.19.1.H**	**TITLE:** *Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients*
Performing Provider Name: *Community Care Collaborative*			***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.17* *307459301.3.18*	*1.9* *1.10*	*Depression Management: Depression Remission at Twelve Months* *Diabetic Care: HbA1c poor control*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 Estimated Incentive Payment: $1,368,065	entered into the registry Goal: 300 patients are identified, entered into the registry, and enrolled in the intervention Data Source: EHR Milestone 4 Estimated Incentive Payment $ 842,373 **Milestone 5 [I-25] - Identify patients with depression and diabetes entered into registry who receive instructions appropriate for their chronic disease according to health intervention care protocols.** Goal: 300 patients with diabetes and depression receive instructions according to the health intervention care protocols. Data Source: Chronic disease registry; EHR Milestone 5 Estimated Incentive	according to the health intervention care protocols. Data Source: Chronic disease registry; EHR Milestone 5 Estimated Incentive Payment $ 842,373 **Milestone 8 [P-X] - Participate in a learning collaborative** **<u>Metric 8 [P-X.1]</u>** Hold at least 2 learning collaborative sessions with relevant partners to assess existing processes for patients in the target population, and make adjustments to existing processes as needed. Goal: Hold a minimum of 2 learning collaborative sessions with relevant partners. Assess and discuss referral and treatment protocols – develop refinements in referral and care management approach.	Data Source: Chronic disease registry; EHR Milestone 10 Estimated Incentive Payment $ 660,531 **Milestone 11 : - [P-X]. Participate in a learning collaborative** **<u>Metric 11 [P-X.1]</u>** Hold at least 2 more learning collaborative sessions with relevant partners to assess existing processes for patients in the target population, and make adjustments to existing processes as needed. **<u>Goal</u>**: Hold a minimum of 2 additional learning collaborative sessions with relevant partners. Assess and discuss referral and treatment protocols – develop refinements in referral and care management approach. Data Source: Information from providers about the referral from

307459301.2.3	*2.19.1*	**2.19.1.B** **2.19.1.C** **2.19.1.D** **2.19.1.E** **2.19.1.F** **2.19.1.H**	**TITLE:** *Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients*
Performing Provider Name: *Community Care Collaborative*			***307459301***
Related Category 3 Outcome Measure(s):	*307459301.3.17* *307459301.3.18*	*1.9* *1.10*	*Depression Management: Depression Remission at Twelve Months* *Diabetic Care: HbA1c poor control*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Payment $ 842,373	Data Source: Information from providers about the referral from primary care physician to the mental health provider, and the data from weekly physician-led case reviews will inform the effectiveness of the care management approach. Milestone 8 Estimated Incentive Payment $ 823,373	primary care physician to the mental health provider, and the data from weekly physician-led case reviews will inform the effectiveness of the care management approach. Milestone 11 Estimated Incentive Payment $ 665,032 Milestone 11 [P-X] – Incorporate proposed improvements from Learning Collaboratives held in DY4. Data Source: Documentation of process improvements in the care management approach. Milestone 11 Estimated Incentive Payment $665,032
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 2,736,130	Year 3 Estimated Milestone Bundle Amount: $2,527,120	Year 4 Estimated Milestone Bundle Amount: $2,470,118	Year 5 Estimated Milestone Bundle Amount: $1,995,095
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $9,728,463			

Performing Provider: Community Care Collaborative
Project Name: Sexually Transmitted Disease Screening, Treatment, and Prevention
Project Identifier: 307459301.2.4 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): This project will provide STD screening and treatment, and HIV testing and referral for positive HIV tests for low-income and Medicaid eligible individuals at risk for STD and HIV transmission. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project will lead to increased screening and treatment, reduced infection rates, and improved utilization of services in target populations with identified disparities.

Need for the project: Texas has the 3rd highest rate of diagnosed HIV cases in the U.S. and 10th highest rate among teens. Texas teens also rank among the highest rates in the U.S. for syphilis (4th) and gonorrhea (16th). Travis County has significantly higher rates of STD and HIV infection when compared with Texas and U.S. These are significant public health issues with long-term impacts that can be improved through effective evidence-based screenings and treatments. Untreated STDs can lead to negative health outcomes including pelvic inflammatory disease, cancer, early onset of full blown AIDS, among others.

Target population: The target population for the project is low-income and Medicaid eligible individuals at risk for STD and HIV transmission with an emphasis on individuals under age 25 due to risk factors. The majority of patients will be at or below 200% of the Federal Poverty Level.

Category 1 or 2 expected patient benefits: The project will expand clinic capacity to provide 2000 additional patient visits in DY3, 2,750 patient visits in DY4, and 3,250 patient visits in DY5 for STD screening and HIV tests. By DY5, this project will serve approximately 2,700 patients annually. An estimated ten percent of all tests are expected to be positive; these individuals will be treated in the clinic for STDs and/or referred out for HIV treatment as appropriate. Treatment and referral will be for 200 patient visits in DY3, 275 in DY4 and 325 in DY5.

Category 3 outcomes:

- IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea*
- IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia*
- IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *HIV*
- *Baseline rates and percentage improvement targets for all Category 3 outcomes will be set in DY2 and DY3.*

Title of Project: **Sexually Transmitted Disease Screening, Treatment, and Prevention**
Category / Project Area / Project Option: **2.7.1. Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations to implement evidence-based project to expand capacity for sexually transmitted disease screening, treatment and prevention.**
RHP Project Identification Number: **307459301.2.4 Pass 3**
Performing Provider Name: **Community Care Collaborative**
Performing Provider TPI: **307459301**

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will expand clinic capacity to provide an increase of 3,000 patient visits by DY5 for Sexually Transmitted Disease (STD) screenings and HIV tests for low-income uninsured or Medicaid eligible individuals. These patients will benefit from expanded screening and treatment as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- Pregnancy Prevention
- Community Paramedic Navigator Project

Within this project, expanded screening and treatment of the most common STDs will be provided through the medical staff at three Austin health centers, with outreach focused at a clinic located in central East Austin, in particular because this clinic experiences the highest volume for the most at risk populations. These services will be made available to any individual meeting eligibility criteria. According to the Centers for Disease Control (CDC), half of all new infections each year occur among this age group and 1 in 4 are estimated to have an infection by age 24. Within Travis County, males experience higher reported numbers of cases of Gonorrhea, Syphilis and HIV while women have higher numbers of Chlamydia infections. STD rates disproportionately impact African Americans and in the case of Chlamydia Hispanics as well. Austin Travis County Health and Human Services Department (ATCHHSD - local public health department) reported that in 2010 there were approximately 1500 Chlamydia cases reported for women compared to over 4,000 cases among men. The reported number of primary and secondary syphilis cases among men was just over 70 in 2010. In Travis County, Chlamydia, Gonorrhea and Syphilis infection rates per 100,000 are significantly higher rates when compared with Texas and the U.S. For example, the infection rate for Gonorrhea in Travis County in 2010 was 146.3 per 100,000 population as compared with the state rate of 124.0 per 100,000 and national rate of 100.8 per 100,000. According to ATCHHSD, there were 197 newly reported HIV infections in Travis County in 2010 (a number which is probably underreported as it only counts confidential testing, not anonymous). The largest number of infections are among Whites, however, trends indicate that African Americans experience the highest rate of infection in the county.

STDs are preventable and, when undetected and untreated, become a serious public health problem. STD related issues include:

- Transmission to partners thereby increasing total numbers
- Cause other conditions including, pelvic inflammatory disease (PID), cervical cancer, and other Human Papillomavirus (HPV)-related cancers, and sterility
- Cause adverse health conditions in newborns,
- Increase a person's risk for transmitting and acquiring HIV infection

In addition to the serious health consequences of STDs, the CDC reports that STDs drive an estimated $17 billion dollars in healthcare costs each year in the U.S. Prevention programs can help mitigate these costs. According to the CDC's published formulas, the averted sequelae costs associated with treating women for chlamydia, for example, is $1,995 (in 2006 US dollars). *(Cost Effectiveness and Resource Allocations; Formulas for estimating the costs averted by sexually transmitted infection (STI) prevention programs in the United States; Harrell W Chesson*, Dayne Collins and Kathryn Koski; Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC).*

Expanded access to STD screening and treatment services will ensure that more patients receive the right care at the right time in the right setting before STD transmission or adverse health effects from untreated STD occurs. This project will provide easy to access testing and treatment through walk-in hours 6 days per week, allowing patients to come at times that are convenient for them including walkins. Same day, on site test results for some STDs will allow clients with identified STDs to receive the initial treatment or medication at

the screening visit. Clinic will also provide client delivered partner therapy (per medical protocol) which allows individuals testing positive in a clinic setting for Chlamydia to receive a prescription for his/her partner. Three month follow-up appointments are scheduled for clients receiving treatment for specific STDs as appropriate.

Existing established clinics will target outreach efforts by utilizing bilingual health staff to engage specific populations and increase referrals through existing clients. Bilingual health educators work with multiple partner agencies such as community colleges, substance abuse treatment centers, nonprofits, and school districts to provide STD health education and referral information. Additionally, health educators will be deployed for specific target populations, such as males, African Americans, and Hispanic who consistently demonstrate the highest rates for STD and HIV infections. The Community Care Collaborative and its network of safety net providers will work together to ensure eligible individuals are aware of the convenient, one stop option being made available.

Project Goals

This DSRIP 2.7.1 project will provide:

- Increased STD and/or HIV screenings
- Increased STD treatment and/or HIV referral for treatment
- Reduced STD infection rates among the targeted population
- Improved utilization of services in target populations with identified disparities

Challenges or Issues Faced by the Performing Provider

A number or issues create barriers and make tackling this health issue a challenge:

- Lack of awareness of STDs (STDs can be asymptomatic, especially in early stages)
- Stigma surrounding STD testing
- Lack of health insurance and ability to pay for STD screenings and treatment
- Creating accessible services to meet clients' needs
- Treatment compliance and partner treatment

How the Project Addresses those Challenges/Issues

This Project will address these challenges by:

- Expanding targeted bilingual outreach, particularly to male, African Americans, and Hispanic clients, that increases awareness of the importance of testing and treatment.
- Providing counseling and testing by trained, experienced, bilingual staff in order to help increase client comfort and reduce stigma for clients seeking testing services.
- Providing services at no cost to the client, eliminating the cost barrier and increasing access to services.
- Providing walk-in appointments and remaining open 6 days per week in order to make services more accessible and flexible for the client.
- Providing onsite same day test results and treatments for appropriate STDs and providing partner-provided treatment prescriptions to infected individuals infected with Chlamydia that they can deliver directly to their partners. Scheduling 3 month follow-up appointments to determine treatment compliance and effectiveness.

How the Project is Related to RHP Goals

This project aligns with Regional Healthcare Partnership 7's Goals 1 and 2:
1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations; and
2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

5-Year Expected Outcome for Providers and Patients: This project expects to provide capacity for 2000 additional patient visits in DY3, 2,750 patient visits in DY4, and 3,250 patient visits in DY5 for STD screening and HIV tests. By DY5, this project will serve approximately 2,700 patients annually, at an average of 1.2 visits per patient per year. An estimated 10% of screening tests show positive STD results and subsequent STD treatment or referral (for HIV). These individuals will be treated in the clinic for STDs and/or referred out for HIV treatment as appropriate. Treatment and referral will be for 200 patient visits in DY3, 275 in DY4 and 325 in DY5.

Starting Point/Baseline

Baseline Data

Baseline data (current patient visits, STD rates, and HIV rates) for the specific patient population will be established during DY2. Baseline data for community activities attended and at risk individuals reached will be established based on existing standards for bi-lingual community health educators (4 community activities / month reaching 75 people each).

Rationale

Reason for Selection of Project Options and Components

2.7.1 Implement evidenced based strategies to increase appropriate use of technology and testing for targeted populations

This project will improve the reproductive and sexual health of the targeted population who are at risk of STD/HIV infection by providing outreach, testing, treatment and referral. Untreated infections may result in serious health issues including transmission to others, cancers, infertility and negative birth outcomes for newborns. Travis County has a higher rate of infection for some of the most common STDs when compared with the state and the nation. Reproductive and sexual health is one of the seven priorities identified in the National Prevention Strategy published by the National Prevention Counsel and the Office of the Surgeon General. This Project provides services that address two of the four specific recommendations put forth in the strategy: sexual health education; and early detection and treatment of STDs.

Current testing and treatment resources are not sufficient to meet the demand. The project will deploy health educators to educate at risk populations on the risks of exposure and lack of treatment as well as addressing the stigma surrounding testing.

Reason for Selection of Milestones & Metrics

The metrics selected reflect salient health needs of the population most at risk for STD and HIV transmission, including access to outreach, education, counseling, testing and treatment for STDs and HIV. This project will implement an evidence-based intervention, specifically STD screenings and treatment for clients at risk for STD infection and transmission. The

project will employ a dedicated Bi-Lingual Community Health Educator (BCHE) who will partner with community based organizations throughout Travis County to outreach to and provide health education information for vulnerable and at risk populations for STDs and HIV. The project will also develop and produce educational materials specific to the project.

Screenings (urine, blood or culture) will be provided to clients at risk for STDs. Treatment for Chlamydia, and Gonorrhea will be provided on-site at screening to clients as medically appropriate. Patients will be treated with the recommended regimens, unless therapeutic compliance is in question, symptoms persist, or re-infection is suspected. The provider relies heavily on the efficacy of client education and follow-up program to track clients who have tested positive with an STD. Clients who have tested positive for HIV or Syphilis are referred out for treatment.

DY2 includes P-2 to integrate STD and HIV counseling into visits for clients who are at risk for STD and HIV transmission, P-X to hire 1 Bi-lingual Community Health Educator (BCHE), and P-X to identify a list of key social service agencies that serve men, women, and adolescents at risk for STDs and HIV and create a yearly calendar of targeted community health events to promote STD and HIV testing. During DYs 3 through 5, P-X will be used to document ongoing monthly community health events by the BCHE. Improvement milestones in DYs 3 through 5 will demonstrate increased clinic capacity for patients receiving STD screening and HIV tests (I-5). Additional process milestones include participation in face-to-face learning collaboratives (P-7) and execution of an evaluation process to determine the efficacy of STD/HIV outreach, education, and treatment. (P-4). Data sources to report metrics include EHR, personnel records, scheduling system, and other clinic documentation.
Health centers maintain a process of continuous quality improvement (CQI) through systematic data collection, analysis and assessment, improvement identification, process design, communication, and ongoing evaluation of outcomes to ensure high quality health services. CQI program combines compliance, risk and quality oversight and includes data-driven and data-based performance measurements tracked daily, and weekly. Clinical care is monitored and evaluated through weekly meetings of a clinical core team (VP of Health Services, Chief Medical Officer, CQI staff and health center directors). The committee assesses data obtained from internal and external audits, and formulates plans to ensure continuous quality improvement. All STD medical protocols are updated annually to meet CDC guidelines and are updated more frequently when new CDC guidelines on testing and treatment are issued. For this project, CQI will include a survey of providers, staff, and/or patients to determine efficacy of STD/HIV outreach, education, and treatment and refine future interventions based on results.

Unique Community Need Identification Number
CN.13 - Higher rates of STDs in Travis County than Texas state averages

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This project significantly enhances the existing delivery system as the expansion of services will improve access to STD/HIV testing and treatment services for at risk populations.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
There are no related activities funded by DHHS.

Related Category 3 Outcome Measure(s)
Category 3 Outcome Measures(s) Selected
OD- 11 Addressing Health Disparities in Minority Populations

- IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea*
- IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia*
- IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *HIV*

Reasons/Rationale for Selecting the Outcome Measure(s)
Available data from ATCHHSD, the local public health department, demonstrate disparities for rates of STD and HIV infection among minority populations. Over the past decade, African Americans have shown the highest rate of Gonorrhea, and African Americans and Hispanics have shown the highest rates of Chlamydia. African Americans also experience the highest rate of HIV infection.

Through targeted outreach and health educators, this project aims to improve utilization rates of clinical preventive services among African Americans for Gonorrhea, Chlamydia, and HIV. Bilingual health staff will also support improved utilization rates of clinical preventive services among Hispanics, with a focus on Chlamydia screening and treatment.

Relationship to Other RHP Projects
How Project Supports, Reinforces, Enables Other Projects
The CCC's fourteen projects (listed within the project description) are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. This project has a similar target population to the CCC's project for Adolescent and Young Adult Pregnancy Prevention (307459301.2.5).

List of Related Category 4 Projects:
RD-1 Potentially Preventable Admissions

Relationship to Other Performing Providers' Projects in the RHP
List of Other Providers in the RHP that are Proposing Similar Projects
This project has a similar target population to the City of Austin Health & Human Services Department project for Adult Immunizations to High Risk Populations (201320302.2.6).

Plan for Learning Collaborative
Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls

that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.2.4	2.7.1	2.7.1	Expanded Capacity for Sexually Transmitted Disease Screening, Treatment, and Prevention	
Community Care Collaborative				307459301
Related Category 3 Outcome Measure(s):	*307459301.3.19*	*IT-11.3*	*Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Gonorrhea*	
	307459301.3.20	*IT-11.3*	*Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Chlamydia*	
	307459301.3.21	*IT-11.3*	*Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – HIV*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2] Implement evidence-based innovational project for targeted population **Metric 1** [P 2.1]: Integrate STD and HIV counseling into visits for male and female clients seeking birth control or preventative care, who are at risk for STD and HIV transmission. **Goal:** Document implementation strategy and outcomes **Data Source**: Patient demographics / EHR documentation/scheduling system Milestone 1 Estimated Incentive Payment *(maximum amount):* $311,055 **Milestone 2 [P-X]:** Hire personnel to support project intervention Metric 1 [P-X]: Hire a dedicated Bilingual Community Health Educator **Baseline:** 0 Bilingual Community	**Milestone 4 [P-X]:** Community or population outreach and marketing Metric 1 [P-X]: Conduct monthly outreach events **Baseline:** No outreach plan in 2012 **Goal**: 4 events per month, reaching an average of 75 people for each event **Data Source**: Documentation of events Milestone 4 Estimated Incentive Payment *(maximum amount):* $287,994 **Milestone 5 [I-5]:** Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model **Metric 1** [I-5.1]: Total number of STD and HIV tests provided to clients <25		**Milestone 7 [P-X]:** Community or population outreach and marketing Metric 1 [P-X]: Conduct monthly outreach events **Baseline:** No outreach plan in 2012 **Goal**: 4 events per month, reaching an average of 80 people for each event **Data Source**: Documentation of events Milestone 7 Estimated Incentive Payment *(maximum amount):* $214,561 **Milestone 8 [I-5]:** Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model **Metric 1** [I-5.1]: Total number of STD and HIV tests provided to clients <25 years and ≤ 200% FPL. **Baseline/Goal**: 750 additional patient	**Milestone 11 [P-X]:** Community or population outreach and marketing Metric 1 [P-X]: Conduct monthly outreach events **Baseline:** No outreach plan in 2012 **Goal**: 4 events per month, reaching an average of 85 people for each event **Data Source**: Documentation of events Milestone 11 Estimated Incentive Payment *(maximum amount):* $179,399 **Milestone 12 [I-5]:** Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model **Metric 1** [I-5.1]: Total number of STD and HIV tests provided to clients <25 years

307459301.2.4	2.7.1	2.7.1	Expanded Capacity for Sexually Transmitted Disease Screening, Treatment, and Prevention	
Community Care Collaborative				307459301
Related Category 3 Outcome Measure(s):	*307459301.3.19* *307459301.3.20* *307459301.3.21*	*IT-11.3* *IT-11.3* *IT-11.3*	*Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Gonorrhea* *Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Chlamydia* *Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – HIV*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Health Educator dedicated to STD/HIV prevention **Goal**: 1 Bilingual Community Health Educator dedicated to STD/HIV prevention **Data Source**: Clinic Documentation / Personnel Records Milestone 2 Estimated Incentive Payment *(maximum amount):* $311,054 **Milestone 3 [P-X]:** Community or population outreach and marketing Metric 1 [P-X]: Identify a list of key social service agencies that serve men, women, and adolescents at risk for STDs and HIV and then create a yearly calendar of targeted community health events to promote STD and HIV testing **Baseline:** No outreach plan in 2012	years **Baseline:** TBD in DY2 **Goal**: increase of 2000 patient visits over DY2 baseline **Data Source**: Patient registry /scheduling system Milestone 5 Estimated Incentive Payment *(maximum amount):* $287,994 **Milestone 6 [P-4]:** Execution of evaluation process for project innovation Metric 1 [P-4.1]: Document evaluative process, tools, and analytics **Baseline:** No current evaluation process for STD /HIV outreach,		visits, 2,750 total increase over DY2 baseline **Data Source**: Patient registry /scheduling system Milestone 8 Estimated Incentive Payment *(maximum amount):* $214,560 **Milestone 9 [P-4]:** Execution of evaluation process for project innovation Metric 1 [P-4.1]: Document evaluative process, tools, and analytics **Baseline:** No current evaluation process for STD /HIV outreach, education, and treatment **Goal**: Survey providers, staff, and/or	**Baseline/Goal**: 750 additional patient visits, 3,250 total increase over DY2 baseline **Data Source**: Patient registry /scheduling system Milestone 12 Estimated Incentive Payment *(maximum amount):* $179,398 **Milestone 13 [P-4]:** Execution of evaluation process for project innovation Metric 1 [P-4.1]: Document evaluative process, tools, and analytics **Baseline:** No current evaluation process for STD /HIV outreach, education, and treatment **Goal**: Survey providers, staff, and/or patients to determine efficacy of

307459301.2.4	2.7.1	2.7.1	Expanded Capacity for Sexually Transmitted Disease Screening, Treatment, and Prevention	
Community Care Collaborative				**307459301**
Related Category 3 Outcome Measure(s):	*307459301.3.19* *307459301.3.20* *307459301.3.21*	*IT-11.3* *IT-11.3* *IT-11.3*	*Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Gonorrhea* *Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Chlamydia* *Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – HIV*	
Year 2 (10/1/2012 – 9/30/2013)	**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: Yearly calendar of targeted community health events to promote STD and HIV testing **Data Source**: Clinic Documentation / Event Calendar Milestone 3 Estimated Incentive Payment *(maximum amount):* $311,054	education, and treatment **Goal**: Survey providers, staff, and/or patients to determine efficacy of STD/HIV outreach, education, and treatment. Refine intervention based on results. **Data Source**: Clinic documentation Milestone 6 Estimated Incentive Payment *(maximum amount):* $287,994		patients to determine efficacy of STD/HIV outreach, education, and treatment. Refine intervention based on results. **Data Source**: Clinic documentation Milestone 9 Estimated Incentive Payment *(maximum amount):* $214,560 **Milestone 10** [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Metric 1** [P-7.1]: Participate in semi-	STD/HIV outreach, education, and treatment. Refine intervention based on results. **Data Source**: Clinic documentation Milestone 13 Estimated Incentive Payment *(maximum amount):* $179,398 **Milestone 14** [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

307459301.2.4	2.7.1	2.7.1	Expanded Capacity for Sexually Transmitted Disease Screening, Treatment, and Prevention	
Community Care Collaborative				**307459301**
Related Category 3 Outcome Measure(s):	*307459301.3.19* *307459301.3.20* *307459301.3.21*	*IT-11.3* *IT-11.3* *IT-11.3*	*Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Gonorrhea* *Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Chlamydia* *Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – HIV*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semi-annual meetings, including meeting agendas, slides from presentation, and/or meeting notes Milestone 10 Estimated Incentive Payment *(maximum amount):* $214,560	**Metric 1** [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semi-annual meetings, including meeting agendas, slides from presentation, and/or meeting notes Milestone 14 Estimated Incentive Payment *(maximum amount):* $179,398
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 933,163	Year 3 Estimated Milestone Bundle Amount: $ 863,982		Year 4 Estimated Milestone Bundle Amount: $ 858,241	Year 5 Estimated Milestone Bundle Amount: $ 717,593
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* **$ 3,372,979**				

Performing Provider: Community Care Collaborative
Project Name: Adolescent and Young Adult Pregnancy Prevention
Project Identifier: 307459301.2.5 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): This project will implement evidence-based services to expand access to long-acting, reversible contraception for uninsured adolescents and young adult women. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project will lead to increased contraceptive education and counseling, increased use of long-acting, reversible contraception, and reduced pregnancy rates among females at risk for unintended pregnancies.

Need for the project: Texas has a higher rate of unintended pregnancies as a percentage of all pregnancies than U.S. as a whole. In Travis County, approximately 10% of all births are to females under age 20, with significantly higher rates for African Americans and Hispanics when compared with Whites. For uninsured and low-income women, long-acting reversible contraception is a preferred and appropriate strategy for preventing unintended pregnancies and supporting healthy birth spacing yet is out of reach to due to the cost.

Target population: The target population for the project is low-income and Medicaid eligible females at risk for unintended pregnancy, with an emphasis on adolescents and young adults. The majority of the patients served will be at or below 200% of the Federal Poverty Level.

Category 1 or 2 expected patient benefits: This project will expand capacity for 500 patient visits in DY3, 550 patient visits in DY4, and 650 patient visits in DY5. These patients will benefit from increased contraceptive education and counseling, increased access to long-acting, reversible contraception, reduced rates of unintended pregnancy, and improved health outcomes.

Category 3 outcomes: IT-1.20 Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies. Baseline rates and percentage improvement targets will be set in DY2 and DY3.

Title of Project: **Adolescent and Young Adult Pregnancy Prevention**

Category / Project Area / Project Option: 2.6.4 Implement other evidence-based health promotion program in an innovative manner: Adolescent and Young Adult Pregnancy Prevention

Project Goal: Implement evidence-based project to expand access to long-acting, reversible contraception for uninsured adolescents and young adult women to prevent unintended pregnancies and improve health status.

RHP Project Identification Number: **307459301.2.5**

Performing Provider Name: **Community Care Collaborative (CCC)**

Performing Provider TPI: **307459301**

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and developmental disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

This CCC project will implement evidence-based services to expand access to long-acting, reversible contraception for uninsured adolescents and young adult women to prevent unintended pregnancies and improve health status. These patients will benefit from improved health outcomes by preventing unintended pregnancies as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Community Paramedic Navigator Project

This CCC Project will provide, through the medical staff at health centers in Austin, medical interventions to prevent unintended pregnancies among adolescents and young adults under the age of 25. According to the U.S. Health and Human Services Department, women ages 18 to 24 and with incomes below the poverty line are among those most at risk for unintended pregnancy. Preventing unintended pregnancy among this population is a goal under Healthy People 2020 and a priority for the Centers for Disease Control. According to the CDC, births resulting from unintended pregnancies result in negative public health outcomes including delays in initiation of prenatal care, preterm birth and low birth weight. Low income females who are uninsured are less likely to have access to family planning services, particularly the most effective long-acting reversible contraception (LARCs), according to data from the U.S. Bureau of Vital Health Statistics.

This project will implement evidence-based health screenings and assessments to provide long-acting reversible contraception (LARCs) including IUDs and implants, to uninsured and Medicaid eligible women at risk for unintended pregnancies and accompanying negative health outcomes. Project will target both nulliparous and parous women.

Texas has a higher rate of unintended pregnancies as a percentage of all pregnancies than U.S. as a whole according to the Guttmacher Institute. In Travis County, approximately 10% of all births are to females under age 20 with significantly higher rates for African Americans and Hispanics when compared with Whites (*Austin/Travis County Health and Human Services Department, 2012 Critical Health Indicators Report*). If cost were not a barrier, many women would choose LARCs to support healthy birth spacing and pregnancy prevention (*Obstetrics & Gynecology: October 2012)*. LARCs have a one-time insertion cost but are 99% effective, safe, reversible, and recommended by the American College of Obstetricians and Gynecologists to promote healthy birth spacing and reduce unintended pregnancies among women under age 25. Once inserted by medical professionals, LARCs require little to no maintenance by clients, have higher compliance rates than other birth control methods, and can remain effective for 3-10 years, depending on the method. For uninsured women, barriers to this method of pregnancy prevention and spacing include lack of awareness of the effectiveness of LARCs, lack of health insurance, and the high one-time cost of this method (approximately $850). This project would provide clients at risk for unintended pregnancy with an initial health screening and assessment to determine medical appropriateness and client preference for LARCs. A second appointment would be scheduled for insertion of IUD or implant at health clinic by trained and experienced professional medical staff.

Project Goals
The goals of the project are:
1. Increase the number of health screening exams, expand contraceptive education and counseling, and utilize contraceptive assessment screening tool for clients at risk for unintended pregnancy (year 3)
2. Increase the use of long-acting reversible contraception to medically-appropriate patients, review risks and advantages of LARCs, insertion provided by medical professionals (year 3)
3. Reduce unintended pregnancy rates among target populations through LARC surveillance and maintenance (year 4 and year 5)

The medical staff at clinics will provide health screenings, and contraceptive counseling and assessment, and long-acting contraception to appropriate clients using evidence-based strategies for clients at risk for unintended pregnancies.

Challenges or Issues Faced by the Performing Provider
Challenges and Issues include:
- Lack of awareness of the existence, appropriateness, and availability of LARCs
- Lack of health insurance and financial resources to afford LARCs
- Expanding the availability of health screenings, and contraceptive counseling and contraceptive assessments to women under age 25 at risk for unintended pregnancy
- Provider will need to utilize bilingual heath education staff to provide culturally appropriate counseling on pregnancy prevention, contraceptive methods and birth spacing. Recruiting for medical assistants to conduct contraceptive counseling and education can be challenging, especially bilingual medical staff.

How the Project Addresses those Challenges
This Project will address these challenges by:

- Providing clients with verbal and written information (Spanish/English) on the use, effectiveness, and medically recognized benefits and risks of LARCs by trained bilingual health center staff
- Offer contraceptive health assessments to clients under age 25 to identify clients medically appropriate for LARCs
- Providing health assessment and as appropriate LARC insertion at no cost
- Utilize bilingual trained heath education staff to provide culturally appropriate counseling on pregnancy prevention, contraceptive methods and birth spacing.
- Conduct on-going staff recruitment led by HR staff to ensure adequate health center staffing for project.

How the Project is Related to RHP Goals
The Project aligns with Regional Healthcare Partnership 7's Goals 1 and 2:
1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations; and
2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

5-Year Expected Outcome for Providers and Patients: This project expects to expand capacity for 500 patient visits in DY3, 550 patient visits in DY4, and 650 patient visits in DY5. These patients will benefit from increased contraceptive education and counseling, increased access to long-acting, reversible contraception, reduced rates of unintended pregnancy, and improved health outcomes.

Starting Point/Baseline

Baseline Data

Baseline data for the specific patient population will be established during DY2. The baseline of contraceptive patient visits across three health clinics for 2012 was 7,000 visits. This data will be broken out in more detail specific to the target population during DY2, including by age group and type of contraception.

Rationale

Reason for Selection of Project Options and Components

According to the U.S. Health and Human Services Department, women ages 18 to 24 with incomes below the poverty line are among those most at risk for unintended pregnancy. Women with lower levels of income, and without health insurance are less likely to have access to family planning services, particularly the most effective long-acting reversible contraception (LARCs) according to data from the U.S. Bureau of Vital Health Statistics. Previous analysis has found that direct medical costs of unintended pregnancies are $4.5 billion annually, and 53% of these may be attributed to poor contraceptive adherence. If 10% of women aged 20-29 switched from oral contraceptives to LARCs, cost savings of more than $200 million in health care could be generated (*American Public Health Association, Burden of Unintended Pregnancies in the U.S.; James Trussell, Oct. 29, 2012*).

According to the CDC, births resulting from unintended pregnancies can result in negative public health outcomes including delays in initiation of prenatal care, preterm birth and low birth weight. It is estimated that the average annual cost to taxpayers of teen births is $1,430 per mother per year (*www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13*). According to the same source, previous studies have shown that family planning services saved nearly $4 in Medicaid expenditures for pregnancy-related care for every $1 spent. Low income and minority females bear a higher burden of unintended pregnancy and have the fewest resources with which to address the issue and its consequences (*Brookings Institute: The High Cost of Unintended Pregnancy, July 2011).* Long-acting forms of contraception are 20 times more effective than short-term methods of contraception and are appropriate for at risk women under age 24 in preventing unintended pregnancies, according to a recent study published by the *New England Journal of Medicine*, yet the one-time cost of the long-term methods is a barrier to usage. Per American College of Obstetricians and Gynecologists recommendations, providing access to long-acting contraceptive methods (such as IUDs and implants) to nulliparous and parous women who seek this method, and prefer this method, but can't afford the out-of-pocket expense, improves health outcomes and reduces public health costs.

Reason for Selection of Milestones & Metrics

Per American College of Obstetricians and Gynecologists (ACOG) clinician guidelines, LARCs are recommended for women at high risk for unintended pregnancy due to high effectiveness rate in reducing unintended pregnancy, high continuation rate among use women, and medical appropriateness for young women, including nulliparous and parous women. LARC methods are

recommend by ACOG as first-line contraceptive methods and encouraged as option for most women due to research indicating few contraindications and medical appropriateness for almost all women.

DY2 includes P-X milestones to develop a plan to integrate LARC education and counseling into visits for clients seeking birth control or preventive care, develop and distribute community outreach and marketing materials, and establish a baseline of patient visits for clients under 25 years old receiving LARCs. DY3 includes implementation of LARC education and counseling (P-3). Improvement milestones in DYs 3 through 5 will demonstrate increased numbers of patients receiving LARCs to prevent unintended pregnancies (I-6), with an increase of 500 patient visits in DY3, 550 patient visits in DY4, and 650 patient visits in DY5. Additional process milestones include participation in face-to-face learning collaboratives (P-8) and execution of an evaluation process to determine the efficacy of project outreach and counseling (P-5). Data sources to report metrics include EHR, scheduling system, and other clinic documentation.

Health centers maintain a process of continuous quality improvement (CQI) through systematic data collection, analysis and assessment, improvement identification, process design, communication, and ongoing evaluation of outcomes to ensure high quality health services. CQI program combines compliance, risk and quality oversight and includes data-driven and data-based performance measurements tracked daily, and weekly. Clinical care is monitored and evaluated through weekly meetings of a clinical core team (VP of Health Services, Chief Medical Officer, CQI staff and health center directors). The committee assesses data obtained from internal and external audits, and formulates plans to ensure continuous quality improvement. For this project, CQI will include a survey of providers, staff, and/or patients to determine efficacy of outreach and counseling and refine future interventions based on results.

Unique Community Need Identification Number
CN12: Lack of adequate prenatal care
CN.17 Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative
This Project significantly enhances the existing delivery system by expanding access to services to additional uninsured and Medicaid eligible women will improve access to long acting, reversible contraception, reduce public health costs, and promote healthy birth spacing.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
There are no related funded activities.

Related Category 3 Outcome Measure(s)
Category 3 Outcome Measures(s) Selected
OD-1: Primary Care and Chronic Disease Management
IT-1.20 Other Outcome Improvement Target: Reduction of Pregnancy Rate among Females at Risk for Unintended Pregnancies

Reasons/Rationale for Selecting the Outcome Measure(s)

Preventing unintended pregnancies among adolescents and young adults is a goal under Healthy People 2020 and a priority for the Centers for Disease Control. IT-1.20 was selected because reducing unintended pregnancies reduces public health costs and improves health outcomes. According to the CDC, births resulting from unintended pregnancies result in negative public health outcomes including delays in initiation of prenatal care, preterm birth and low birth weight. LARCs are 99% effective, safe, reversible, and recommended by the American College of Obstetricians and Gynecologists to promote healthy birth spacing and reduce unintended pregnancies among women under age 25. IT-1.20 will demonstrate the success of LARCs in preventing pregnancies among the target population.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's fourteen projects (listed within the project description) are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. This project has a similar target population to the CCC's project for Sexually Transmitted Disease Screening, Treatment, and Prevention (307459301.2.4).

List of Related Category 4 Projects (RHP Project ID Number)

RD-1: Potentially Preventable Admissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

This project has a similar target population to the City of Austin Health & Human Services Department projects for Prenatal & Postnatal Improvement Program (201320302.2.4) and Healthy Families Program Expansion (201320302.2.5) and to University Medical Center at Brackenridge's project for OB Navigation (137265806.2.1).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

Approach and Rationale for Valuing Project

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Of particular relevance to this project is the one-time cost per LARC (approximately $850), which make this highly-effective contraceptive method out of reach for many low-income women. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

It is estimated that the average annual cost to taxpayers of teen births is $1,430 per mother per year (*www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13*). According to the same source, previous studies have shown that family planning services saved nearly $4 in Medicaid expenditures for pregnancy-related care for every $1 spent.

307459301.2.5	2.6.4	2.6.4	Adolescent and Young Adult Pregnancy Prevention	
Community Care Collaborative				307459301
Related Category 3 Outcome Measure(s):	*307459301.3.22*	*IT-1.20*	*Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X] Complete a planning process / submit a plan **Metric 1** [P-X]: Develop plan to integrate LARC education and counseling into visits for clients seeking birth control or preventive care **Baseline:** New project **Goal:** Documentation of plan **Data Source**: Clinic documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $431,060 **Milestone 2 [P-X]:** Establish a baseline Metric 1 [P-X]: Establish baseline of the number of patient visits for clients <25 years receiving LARCs at clinics participating in this intervention **Baseline/Goal**: Establish baseline **Data Source**: Patient demographics / EHR documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $431,060 **Milestone 3 [P-X]:** Community or population outreach and marketing	**Milestone 4 [P-3]** Implement, document, and test an evidence-based project for targeted population: Integrate LARC education and counseling into visits for clients seeking birth control or preventative care. **Metric 1** [P 3.1]: Document implementation strategy and outcomes **Baseline:** New project **Goal:** Documentation of implementation strategy and outcomes **Data Source**: Patient demographics / EHR documentation/scheduling system Milestone 4 Estimated Incentive Payment *(maximum amount):* $399,103 **Milestone 5 [I-6]:** Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model **Metric 1** [I-6.1]: Total number of LARCs inserted for clients <25 years **Baseline:** TBD in DY2 **Goal**: increase of 500 patient visits over DY2 baseline		**Milestone 7 [I-6]:** Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model **Metric 1** [I-6.1]: Total number of LARCs inserted for clients <25 years **Baseline/Goal**: 50 additional patient visits, 550 total increase over DY2 baseline **Data Source**: EHR/ Patient registry /scheduling system Milestone 7 Estimated Incentive Payment *(maximum amount):* $ 396,451 **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	**Milestone 10 [I-6]:** Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model **Metric 1** [I-6.1]: Total number of LARCs inserted for clients <25 years **Baseline/Goal**: 100 additional patient visits, 650 total increase over DY2 baseline **Data Source**: EHR/ Patient registry /scheduling system Milestone 10 Estimated Incentive Payment *(maximum amount):* $ 331,481 **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-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

307459301.2.5	2.6.4	2.6.4	Adolescent and Young Adult Pregnancy Prevention	
Community Care Collaborative				307459301
Related Category 3 Outcome Measure(s):	*307459301.3.22*	*IT-1.20*	*Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-X]: Utilize bilingual educational materials to create an awareness of the efficacy of LARCs. **Baseline:** No previous community or population outreach for LARCs **Goal**: Distribute 500 educational materials to create an awareness of the efficacy of LARCs **Data Source**: Clinic documentation Milestone 3 Estimated Incentive Payment *(maximum amount):* $431,060	**Data Source**: EHR/ Patient registry /scheduling system Milestone 5 Estimated Incentive Payment *(maximum amount):* $399,103 **Milestone 6 [P-5]** Execution of evaluation process for project innovation **Metric 1** [P 5.1]: Document evaluative process, tools, and analytics **Baseline:** No current evaluation process for LARC outreach and counseling **Goal:** Survey providers, staff, and/or patients to determine efficacy of outreach and counseling. Refine intervention based on results. **Data Source**: Clinic documentation Milestone 6 Estimated Incentive Payment *(maximum amount):* $399,103		organized by the RHP. **Data Source:** Documentation of semi-annual meetings, including meeting agendas, slides from presentation, and/or meeting notes Milestone 8 Estimated Incentive Payment *(maximum amount):* $ 396,451 **Milestone 9 [P-5]** Execution of evaluation process for project innovation **Metric 1** [P 5.1]: Document evaluative process, tools, and analytics **Baseline:** No current evaluation process for LARC outreach and counseling **Goal:** Survey providers, staff, and/or patients to determine efficacy of outreach and counseling. Refine intervention based on results. **Data Source**: Clinic documentation Milestone 9 Estimated Incentive Payment *(maximum amount):* $ 396,451	organized by the RHP. **Data Source:** Documentation of semi-annual meetings, including meeting agendas, slides from presentation, and/or meeting notes Milestone 11 Estimated Incentive Payment *(maximum amount):* $ 331,481 **Milestone 12 [P-5]** Execution of evaluation process for project innovation **Metric 1** [P 5.1]: Document evaluative process, tools, and analytics **Baseline:** New project **Goal:** Survey providers, staff, and/or patients to determine efficacy of outreach and counseling. Refine intervention based on results. **Data Source**: Clinic documentation Milestone 12 Estimated Incentive Payment *(maximum amount):* $ 331,481

307459301.2.5	2.6.4	2.6.4	Adolescent and Young Adult Pregnancy Prevention	
Community Care Collaborative				307459301
Related Category 3 Outcome Measure(s):	*307459301.3.22*	*IT-1.20*	*Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 1,293,180	Year 3 Estimated Milestone Bundle Amount: *$* 1,197,309		Year 4 Estimated Milestone Bundle Amount: *$* 1,189,353	Year 5 Estimated Milestone Bundle Amount: *$* 994,443
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* **$ 4,674,285**				

Performing Provider: Community Care Collaborative
Project Name: Community Health Paramedic Navigation Program
Project Identifier: 307459301.2.6 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to low-income Travis County residents with multiple chronic conditions and have frequent recent Emergency Department (ED) utilization. In conjunction with the thirteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project will create patient care plans, connect patients to appropriate resources, and reduce unnecessary ED visits.

Need for the project: Qualitative data collected through surveys and from providers indicate a need for better coordination across settings of care. High rates of unnecessary ED utilization and potentially preventable hospitalizations also point to the need for better care coordination and navigation.

Target population: This project will be targeted Travis County residents at 200% of FPL or below. The majority of these patients are uninsured or on Medicaid.

Category 1 or 2 expected patient benefits: Through this project, the CCC expects to provide short term care management and patient navigation services to approximately 1,200 patients (approximately 3,600 encounters) through DY5.

Category 3 outcomes: IT-9.2 – ED appropriate utilization. Baseline rates and percentage improvement targets will be set in DY2 and DY3.

Title of Project: **Community Health Paramedic Navigation Program**
Category / Project Area / Project Option: **2.9.1 Establish/Expand a Patient Navigation Program**
RHP Project Identification Number: **307459301.2.6**
Performing Provider Name: **Community Care Collaborative**
Performing Provider TPI: **307459301**

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to enroll low-income Travis County residents with multiple chronic conditions and frequent recent ED utilization. These patients will benefit from increased access as described in this project, but also the thirteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Musculoskeletal Care in Community Clinics
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STD & HIV Screening and Treatment & Referrals
- Pregnancy Prevention
- Community Paramedic Navigator Project
-

The Region 7 community needs assessment found that many local safety net providers feel patients struggle with establishing and maintaining connections to appropriate healthcare and social services. Travis County safety net data show that among the population served by the safety net between May

2011-April 2012, more than 50% had potentially preventable Emergency Department visits. The CCC anticipates that many patients in its target population, including those with two or more chronic conditions, may have had little to no consistent contact with the healthcare delivery system and will need initial, intensive home-based support to get connected to regular medical homes and other support services to begin proper management of their conditions. As a result of this home support and navigation service, the CCC expects ED usage among these patients will decrease. The expanded CHP program will provide a bridge into the CCC's system of care at which point care for these patients can be managed actively by the CCC network of case managers and health providers.

The current CHP program began in 2009 upon the realization that a few high utilizers of the 9-1-1 system were incurring a significant number of emergency medical calls, resulting in a significant amount of community resources to support these patients. It was clear the patients were receiving medical care in an inappropriate and ineffective setting. A goal was established to identify the highest utilizers of emergency transport services and to provide navigation and connectivity to the appropriate setting and reduce dependency on the 9-1-1 system as their source of care. In 2012, this program reported a 62% reduction in emergency transport visits for 57 patients identified as high utilizers upon comparison of 9-1-1 utilization from pre-entry and discharge from the program. This proposed CCC project will expand the current program and modify its structure to provide targeted navigation services to CCC patients with two or more chronic conditions and have had two or more visits to the ED within a 30 day time period.

The CHP Navigation Program will perform a key role in the CCC to achieve established goals by providing initial medical assessments in the home of the patient with chronic conditions and high recent ED utilization. Services will vary according to patient needs but may include vital sign assessment, medical screening, home safety assessment, prescription drug assessment, access to a pharmacy and needed prescription refills, establishing appointments for patients with no existing care provider, direct transportation service or arrangement for transportation to medical appointments, behavioral health screening and navigation to appropriate behavioral health services providers. The expanded program will also allow CHP staff to provide certain medical services to patients in the home as governed by care protocols to be developed by the program's medical director.

Travis County has a population of just over 1,000,000 residents. 27% of adults aged 18-64 in Travis County are uninsured. Of the 50,000 patients within the CCC patient population, an estimated 18,000 have multiple chronic conditions. Within this group, congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), and hypertension are top diagnoses. In Travis County and in Region 7 as a whole, rising rates of chronic disease, combined with a growing general and elderly population, will produce an even greater demand for effective chronic disease management. This will place a greater emphasis on access to proper care and patient self-management.

Upon entry to the program, the CHP program will establish contact to schedule a home visit. The CHP is trained to provide first response treatment for the target chronic conditions patient population and will be guided by clinical protocols established by the ATCEMS medical director. The CHP will initiate a questionnaire to establish if the patient has a medical home, is adhering to prescribed medications, and properly self-managing their care. Language barriers will be addressed, as a requirement of the program is that each CHP paramedic speaks both English and Spanish. If

further interpretive services are necessary, the CHP will utilize the language interpretive services offered by the current 9-1-1 system.

Many patients with chronic conditions have mobility issues and are at high-risk for a fall that could result in serious injury or death. According to a report released by the Travis County Medical Examiner, accidental falls were the second highest cause of accidental deaths, with 168 deaths that occurred in 2011 (http://www.co.travis.tx.us/medical_examiner/pdfs/annual_report2011.pdf). Because of this risk, another aspect of the CHP program is a risk assessment of the home and identification of high-risk areas within the home that could result in a serious fall. The risks will be communicated to the patient to help avert this dangerous condition.

Once the initial assessments are completed, the CHP and the patient will work together to create a patient care plan. The CHP will visit the patient at least once a week for a period of up to 30 days to monitor adherence to the patient care plan and continue connecting patients to the appropriate services. including:

- Connection to primary care and scheduling appointments if necessary
- Addressing transportation barriers
- Ensuring appropriate and affordable access to prescriptive medicines
- Navigation to social service needs, including behavioral health
- Reinforcing self-management care instructions to patient or caregiver

Project Goals

- Reduce preventable ED visits among targeted CCC and uninsured patients with multiple chronic conditions
- Provide essential navigation services to allow patients to receive proper care in the most appropriate and cost-effective setting
- Reduce risk of accidental deaths or serious injury by eliminating risk of accidental fall

Challenges or Issues Faced by the Performing Provider

- Patients with multiple chronic diseases and frequent utilizers of the ED may have a number of barriers to care, including language or cultural barriers, or lack of transportation.
- Patients with multiple chronic conditions often have a co-occurring behavioral health issue.
- Establishing and maintaining providers to accept program participants.
- Integrating patient care data from the patient's 30-day care plan into the CCC HIE.

How the Project Addresses those Challenges

- To ensure cultural sensitivity in interacting with patients, all CHPs will be certified by DSHS as Community Health Workers. This certification will help prepare the CHPs to interact with patients in a way that responds best to their cultural needs.
- Spanish and English language skills will be a requirement to be a CHP. Translation services are also available via established 9-1-1 protocols.
- Patients will be linked to current transportation providers as a resource to this program.
- CHP will have links to behavioral health resources within the CCC.

- CHP program staff and the CCC will constantly work to maintain good relationships with providers to ensure smooth transitions for patients into the program and then into needed care settings.
- CHP and CCC technical staff will establish a way through the CCC's HIE to communicate program care plan data and other health information to primary care providers in a seamless fashion.

How the Project is Related to RHP Goals

- Goal 1 - Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
- Goal 2 - Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Goal 3 - Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

- ***5-Year Expected Outcome for Providers and Patients:*** Through this project, the CCC expects to provide short term care management and patient navigation services to approximately 1,200 patients through DY5. Through improved care management and navigation, the CCC aims to reduce preventable ED visits among targeted CCC and uninsured patients with multiple chronic conditions.

Starting Point/Baseline

Baseline Data

0 (New program)

Rationale

Reason for Selection of Project Options and Components

As outlined within the Region 7 Community Needs Assessment, qualitative data collected through surveys and from providers indicate a need for better coordination across settings of care. Quantitative data regarding unnecessary ED utilization and potentially preventable hospitalizations also point to the need for better care coordination and navigation. A 2011 analysis of ED visits by uninsured and underinsured patients in Travis County found that almost 50% of ED visits were for services that could have been provided in a primary care setting. Similarly, DSHS estimates that adult residents of Travis County have approximately 6,000 potentially preventable inpatient hospitalizations per year. Potentially preventable hospitalizations for CHF, diabetes complications, COPD, and hypertension contributed to over $500 million in hospital charges in Travis County between 2005 and 2010.

The Austin/Travis County 2012 Community Health Assessment, which drew heavily from focus groups and resident surveys, also found that transportation challenges, especially for low-income residents, often mean limited access to healthcare services (http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/cha_report_8-24-12.pdf, p. vii).

Project option 2.9.1 includes five required components:

a) **Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train healthcare navigators in cultural competency.** The current system

identifies high ED utilizers through the 9-1-1 system and will expand to include the CCC patient record system, where ED visits will be monitored for frequent utilization. Additionally, a new training component will be added for all community health paramedics in the program to ensure they are certified as Community Health Workers by DSHS. This training includes an emphasis on developing 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.** This program will utilize EMS paramedics that are trained to quickly triage patients and follow known clinical protocols that are under the supervision of the ATCEMS Medical Director. Established "pathways" of available referral options and resources will be developed to facilitate the navigation process.

c) **Connect patients to primary and preventive care.** Connecting enrollees to primary and preventive care is a primary task of the community health paramedic. Frequently, community health paramedics conducting a home visit will call the patient's primary care provider to schedule appointments and arrange transportation to services if needed. Patients without an existing provider will be connected with a Patient Centered Medical Home through the CCC. The goal is to facilitate connections to continued sources of support for improved health.

d) **Increase access to care management and/or chronic care management, including education in chronic disease self-management.** Because the target population is comprised of patients with multiple chronic conditions, specific protocols for addressing chronic disease management will be developed and incorporated into community health paramedic training. Internal systems will be built to ensure that clinical information is regularly communicated between the CCC and field staff.

e) **Conduct quality improvement for project using methods such as rapid cycle improvement.** The current CHP program uses the plan-do-study-act model that is endorsed by the IHI to conduct continuous quality improvement. This activity will be expanded to incorporate the CHP Program. Will also place a focus on improvements to "raise the floor" with all-inclusive meetings with key stakeholders and providers.

Reason for Selection of Milestones & Metrics

During DY 2, the CCC, ATCEMS, and key stakeholders will achieve the milestone P-X -Complete a Planning Process – to develop an expansion plan for the CHP program. Additionally the provider will develop a set of standard operating procedures to govern patient referrals to needed services. Finally, medical program staff will develop a set of clinical protocols to govern CHP medical services provided and the development of the 30-day care plan.

In DY 3, the CCC and ATCEMS will start the process of designating additional community health paramedics to serve in the community health program to achieve milestone P-X – Designate/Hire Personnel to Support/Manage Project. This milestone will also ensure the personnel have the appropriate equipment and vehicles to perform both standard paramedic and CHP functioning. All CHPs will also be certified as CHWs. Additionally, the team will work to incorporate CHP program data, including information from the 30-day care plan, into the CCC HIE. This work will achieve the milestone P-X- Implement, adopt, upgrade, or improve technology to support the project.

In DY 4, the CCC and ATCEMS will bring the program to full staffing (P-X – Designate/Hire Staff) and begin increasing the number of patients served by the program (I-10: Improvements in Access to Care of Patients Receiving Navigation Services, Metric 10.3: Increase patients served by the program). In addition, it will essential to participate in face-to-face meetings with other

providers to make improvements, or "raise the floor" for performance (P-8: Participate in face-to-face meetings to collaborate with providers and improve performance)
In DY 5, the number of patients served will continue to increase (I-10, Metric 10.3).Face-to-face meetings will also continue (P-8: Participate in face-to-face meetings to collaborate with providers and improve performance)

Unique Community Need Identification Number
CN.7 Lack of coordination of care across settings of care, multiple conditions, and/or physical and behavioral health.
CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions
CN.9 High rates of chronic disease such as cardiovascular disease, cancer, and rising rates of diabetes
CN.10 Many residents in Region 7 have multiple chronic conditions

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected:
OD-9 Right Care, Right Setting, IT-9.2 ED Appropriate Utilization

Reasons/Rationale for Selecting the Outcome Measure(s)
This project targets people with multiple chronic conditions, many of whom have a history of accessing emergency services more than three times per month. Frequently, requests for care result in emergency department visits that may not be necessary. Unnecessary ED visits waste time and money for patients and providers alike. The ultimate goal of this project is to ensure patients have access to needed resources so they can receive care for their conditions in the most appropriate setting. When this is achieved, ED usage is expected to decrease.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects
The CCC's fourteen projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Community Health Paramedic Navigation Program are outlined below.

- 307459301.2.1 - Patient-Centered Medical Home
- 307459301.2.2 – Expand Chronic Care Management Models
- 307459301.1.2 – Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.3 – Expand Primary Care via Mobile Health Clinics
- 307459301.1.1 - Disease Management Registry

List of Related Category 4 Projects
RD-1: Potentially Preventable Admissions
RD-2: 30-day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

With its aim to improve management of chronic conditions, this project has a similar target population to University Medical Center Brackenridge's Chronic Care Management for Adults (137265806.2.6) and ATCIC's project to Integrate Primary and Behavioral Health Care Services (133542405.2.1). With its focus on patient navigation, this project also has a similar intervention to the following projects from University Medical Center at Brackenridge:

- 137265806.2.1 – OB Navigation
- 137265806.2.3 – Substance Abuse Disorder Navigation
- 137265806.2.4 – Behavioral Health Assessment and Resource Navigation
- 137265806.2.8 – Women's Oncology Care Navigation
- 137265806.2.6 – Chronic Care Management - Adults

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

Other factors considered include information published by the Texas Department of State Health Services that reports potentially preventable hospitalizations for CHF, diabetes complications,

COPD, and hypertension contributed to over $500 million in hospital charges in Travis County between 2005 and 2010. For each hospitalization averted through improved care management and patient navigation, the potential cost avoidance ranges from approximately $20,000 in average hospital charges per admission for hypertension to more than $36,000 per admission for diabetes long-term complications.

307459301.2.6	***2.9.1***	***2.9.1.A-E***	***COMMUNITY HEALTH PARAMEDIC PATIENT NAVIGATION PROGRAM***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.23*	*IT-9.2*	*ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X] Complete a planning process. Metric 1 Documentation of community health paramedic patient navigator program expansion plan. Baseline/Goal: 0/1 plan Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $616,912 **Milestone 2** [P-X] Develop a new methodology, or refine an existing one based on learnings. Metric 1 Documented set of standard operating procedures for program referrals. Baseline/Goal: 0/1 set of standard operating procedures for referrals Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $616,912	**Milestone 4** [P-X] Designate/hire personnel to support/manage project. Metric 1 Documentation of designation of additional community health paramedics to serve in the patient navigator program Baseline/Goal: 0 navigator staff/1 navigator staff and necessary vehicle and equipment Data Source: Program HR records Milestone 4 Estimated Incentive Payment *(maximum amount):* $571,177 **Milestone 5** [P-X] Implement, adopt, upgrade, or improve technology to support the project Metric 1 Program data, including health information related to the patient's 30-day care plan, are incorporated into the CCC HIE. Baseline/Goal: 0/Functioning HIE with CHP patient data incorporated.		**Milestone 7** [P-X] Designate/hire personnel to support/manage project. Metric 1 Documentation of designation of additional community health paramedics to serve in the patient navigator program Baseline/Goal: 0 navigator staff/3 total navigator staff and necessary vehicle and equipment. Data Source: Program HR records Milestone 7 Estimated Incentive Payment *(maximum amount):* $567,382 **Milestone 8 [P-8]** : Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Participate in semi-annual face-to-face meeting or seminars organized by the RHP Data Source: Documentation of	**Milestone 10 [P-8]** : Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Participate in semi-annual face-to-face meeting or seminars organized by the RHP Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 10 Estimated Incentive Payment: $ 711,600 **Milestone 11** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Baseline: 0 unique patients served in

307459301.2.6	***2.9.1***	***2.9.1.A-E***	***COMMUNITY HEALTH PARAMEDIC PATIENT NAVIGATION PROGRAM***	
Community Care Collaborative				*307459301*
Related Category 3 Outcome Measure(s):	*307459301.3.23*	*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 3 [P-X] Conduct a literature review for evidence based practices and tailor intervention to local context – Develop clinical protocols specific to patients with multiple chronic decisions to guide CHPs on their home visits. Metric 1 Documentation of a set of clinical protocols related to serving patients with multiple chronic diseases. Baseline/Goal: 0/1 set of protocols Data Source: Program records Milestone 3 Estimated Incentive Payment *(maximum amount):* $616,913	Data Source: Program records Milestone 5 Estimated Incentive Payment *(maximum amount):* $571,177 **Milestone 6** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Baseline: 0 unique patients served in 2012 Goal: Increase the number of unique patients served in DY3 from 0 to 100 Data Source: Program records Milestone 6 Estimated Incentive Payment: $571,177		semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 8 Estimated Incentive Payment: $ 567,382 **Milestone 9** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Baseline: 0 unique patients served in 2012 Goal: Increase the number of unique patients served in DY4 to 500 for a cumulative total of 600 patients. Data Source: Program records Milestone 9 Estimated Incentive Payment: $567,382	2012 Goal: Increase the number of unique patients served in DY5 to 600 for a cumulative total of 1200 patients. Data Source: Program records Milestone 11 Estimated Incentive Payment: $711,599
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,850,737	Year 3 Estimated Milestone Bundle Amount: $1,713,531		Year 4 Estimated Milestone Bundle Amount: $1,702,146	Year 5 Estimated Milestone Bundle Amount: $1,423,199
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $6,689,613				

Dell Children's Medical Center (DCMC)
Category 2 DSRIP Projects

DELL CHILDREN'S MEDICAL CENTER (DCMC)
Family and Child Obesity
PROJECT ID: 186599001.2.1 Pass 1

Provider: DCMC is the only Children's Hospital in the region. Austin proper has a population of approximately 820,000 and is located in Travis County, with a population of approximately 1.1 million. The hospital is part of a larger health care system, Seton Healthcare Family, through which it has access to an extensive network for primary, specialty, and emergency care.

Intervention(s): This project deploys a tiered approach to treat and prevent childhood obesity by providing (1) direct intervention to the child and family, (2) best practices and tools to primary care and pediatric clinics and clinicians serving the target population; and (3) multi-media health promotion resources and support activities for patients, families and the community at-large that are designed to comprehensively treat and reduce the incidence of obesity in the region.

Need for the Project: Specifically, this initiative will address the lack of: (1) accessible information on local programming and resources supporting healthy active living; (2) primary care providers' ability to effectively address childhood obesity in their offices; and (3) access to services for the dramatic number of severely/morbidly obese children in Travis County with significant medical problems due to their obesity (CN.1).

Target Population: The target population is Travis County children and adolescents, and their families, who are overweight, obese or at risk for obesity. It will provide direct clinic services and support to children, adolescents and their families over the life of the demonstration, but expected to impact thousands through the project's health promotion activities in the community, with providers and families. The project served is expected to be 65%-70% uninsured or Medicaid recipients.

Category 1 or 2 Expected Patient Benefits: This project will increase the number of children and adolescents who have access to this disease prevention program by increasing one-on-one encounters with a physician, nurse, social worker, dietician and/or physical therapist by 884 encounters in DY3, an additional 864 encounters in DY4 and an additional 860 encounters in DY5. By the end of this project a total of 2,608 encounters will be provided (DY2-DY5).

Category 3 Outcomes: [IT-9.4] Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. We expect to increase by 3% over baseline in DY4, and by 5% over baseline in DY5, the percentage of program participants who have evidence of their body mass (BMI) percentile documented, and received counseling for nutrition and counseling for physical activity during the measurement year. Baseline to determine in DY3 based on program participants, children age 2-18.

Title of Project: Family and Child Obesity

Category/Project Area/Project Options: 2.7.5

RHP Project Identification Number: 186599001.2.1 Pass 1

Performing Provider Name: Dell Children's Medical Center

Performing Provider TPI: 186599001

Project Description

Childhood obesity is an epidemic facing Travis County, where approximately 1/3 of school aged children are overweight or obese. Healthcare alone will not solve the epidemic, but healthcare must be a part of the solution. The Multi-level Family and Child Obesity Initiative is a comprehensive childhood obesity intervention with a tiered approach, increasing the intensity of the intervention depending upon the needs of the child. Specifically, this initiative will address the lack of: (1) accessible information on local programming and resources supporting healthy active living; (2) primary care providers' ability to effectively address childhood obesity in their offices; and (3) access to services for the dramatic number of severely/morbidly obese children in Travis County with significant medical problems due to their obesity. The project will continue the efforts of the Texas Center for the Prevention and Treatment of Childhood Obesity (TCPTCO) to target all children in Travis County, with an emphasis on underserved communities. Briefly, this program will link, expand, and create new services to work with children and their families across multiple settings: the community, primary care clinics, and at ACES (Activating Children Empowering Success), Dell Children's Medical Center's weight management clinic. The programs will be developed and coordinated by the Texas Center for the Prevention and Treatment of Childhood Obesity (TCPTCO), the region's only childhood obesity center. This proposal will expand established programs, develop new projects grounded in evidence-based practices, and provide funding to hire additional providers to develop, coordinate, and implement tiered individual, family, and community programs that empower families to initiate and maintain healthy behavior changes.

This tiered approach can best be visualized as a pyramid. Tier 1, the base of pyramid, will focus on dissemination of information about healthy community programs. Currently there is no centralized place for community members or healthcare providers to find real-time information regarding healthy physical activity, nutrition, and mental health programming. Many valuable community programs have difficulty publicizing and recruiting. This internet based platform, a "visual 2-1-1" so to speak, will be accessible via the internet and printable at home by a caregiver or child, in a community library for those who do not have internet access, by a school counselor, or by a physician or their staff in the clinic. Inability to access program information (e.g. what does the YMCA or city recreation center offering tonight/this week) will no longer be a barrier for children to participate in healthy living programs. Tier 2 would establish a Childhood Obesity Learning Collaborative to greatly expand the ability of Central Texas medical providers to provide care for overweight and obese children in their clinics. The Childhood Obesity Learning Collaborative will link primary care clinics and TCPTCO to provide primary care physicians with tools to address obesity as early as possible and improve quality of life. A small scale pilot of this concept is currently underway through a CDC Childhood Obesity Research Demonstration grant, led by the TCPTCO and the UT School of Public Health. The DSRIP funding mechanism would build on this

work and the knowledge and experience gained over the last year. The DSRIP proposal would not duplicate any work or funding from the CDC grant, but rather it would expand the project and make participation available for far more clinics in Travis County. TCPTCO faculty also received grant funding for one year (ending in 9/12) to assist the Travis County arm of the National Children's Study recruit from primary care clinics in Austin. This grant facilitated additional connections between the TCPTCO and primary care clinics in Austin, but does not duplicate any elements of the DSRIP proposal.

Tier 4, the tip of the pyramid, will expand the more intensive programs offered to children served by TCPTCO who struggle with severe obesity and associated medical complications. Four programs will be included in Tier 4. 1) Expansion of the ACES (Activating Children Empowering Success) Interdisciplinary Weight Management Clinic. ACES weight management clinic provides multidisciplinary clinical care for severely obese children in Austin. The clinic currently has a 1 year waiting list. Expansion would double the number of patient appointments and expand the number of individual dietitian and behavioral health visits that can be offered to patients for intensive and individualized care. The addition of an exercise physiologist will enhance the clinical care and provide a direct link between our clinic and UT-Austin's Department of Kinesiology and Health Education, providing further expertise to examine and address the mechanisms through which interventions impact behavioral and health-related outcomes. 2) Establishment of a Preschool Parent-Child-Interaction Intervention Program. The preschool years are an important time for intervention for families, particularly for preschool-aged children who are already obese. We will establish a parent-child-interaction intervention program at our center, using a multidisciplinary team of behavioral health, nutrition, and physical activity specialists to coach parents through behavioral, feeding, and physical activity interactions. Cost savings to change these toddlers' trajectory for massive future health problems will be maximized by addressing the child's obesity at the earliest possible time point. 3) Expansion of Behavioral Health Group Programs for Teens. Psychological disorders, particularly depression, are strongly linked to obesity and thus a more comprehensive behavioral component is needed to treat these obese adolescents who have a high likelihood of becoming severely obese adults without intervention. Our current pilot teen program extends beyond education to focus on behavioral change by providing teens and their families with skills training and in-vivo experiences related to eating, physical activity, and stress management. Our pilot program demonstrates proof of concept, and further funding will allow us to continue the program and expand it to reach a larger number of families. 4) Establishment of an Interactive Teen Cooking Program. This 8-week program will empower teens and their parents to eat more healthily and move toward a healthier weight through a hands-on interactive curriculum that increases their nutrition knowledge and their food preparation, planning, and cooking skills.

The goal of this project is to implement evidence-based programs to significantly improve the health children who are suffering from severe obesity and its complications who are directly treated by our Tier 4 multidisciplinary weight management clinic, but who also access and are supported by the Tier 1- 2 programs. Children would work with our weight management clinic, with close coordination with their primary care provider and use of the internet and phone based interventions. Many elements of our programs will serve a far broader audience than those who are directly served by the multidisciplinary clinic. Our individual and group clinical programs linked to technology assisted community programs will prevent both the progression of many children's obesity and the development of additional medical complications that arise due to obesity (e.g. high blood pressure, high cholesterol, orthopedic problems, diabetes, depression, etc.). For patients who already have

these complications, we will work to save costs by (1) consolidating services, preventing unnecessary medical visits to additional subspecialists; and (2) improving outcomes, including the obesity itself and associated medical conditions. Our programs are novel and innovative, but also based upon the best available evidence. Our center currently works with a consortium of 25 leading pediatric obesity centers from around the US to collaboratively develop and implement innovative programs and then benchmark against each other qualitatively and quantitatively.

Potential project challenges include that this project requires the hiring of additional expert faculty and staff, and the acquisition of new space, both of which can take time to acquire. During our planning phase year we will specify our needs regarding personnel and space, and the timeline required for both. Projecting the magnitude of our interventions are somewhat difficult due to limited literature regarding the relationship between "Health Related Quality of Life" and obesity in children aged younger than 13 years. Yet this is an important developmental phase during which to intervene due to the effect that obesity has on peer relationships, physical activity, problem solving, mastery, self-efficacy, and self-esteem. Additionally, the earlier we can impact and reverse childhood obesity, the larger the personal health gains and cost savings.

This project addresses several RHP #7 goals. By expanding multidisciplinary clinical programs and extensions to support health change in the community, this infrastructure of clinical content experts and leaders will improve the health of current and future Region 7 populations (RHP Goal #1). This project will project reduce healthcare costs and expand access to appropriate care in the most appropriate setting through managing chronic conditions in an outpatient setting through the use of an interdisciplinary team (RHP Goal #2). It will improve the patient experience of care through taking a patient centered approach that is coordinated across primary care and subspecialty systems (RHP Goal #3), and will bolster individual and population health by improving chronic disease (such as obesity, hypertension and diabetes) management (RHP Goal #4). Behavioral health, including psychiatric care, embedded within the multidisciplinary clinic will expand access to behavioral health services in order to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery (RHP Goal #6). Behavioral health in the context of childhood obesity and parent factors affecting child health (e.g. behavior management skills) will be fully integrated within our program (RHP Goal #6).

5-Year Expected Outcome for Provider and Patients:

The 5 year expected outcome for providers and patients is to great enhance the number of resources, programs and clinical appointments available for children struggling with their weight. We expect thousands more persons in the community will be positively impacted by the programs and resources developed and implemented through this DSRIP project.

Starting Point/Baseline

Baseline data for the proposed expansion of current programs uses patient encounters from no earlier than 12/1/2012 and baseline encounters at the end of DY1 was 160. We will draw upon our experience with existing programs that have been pilot tested, in order to best plan and implement their expansion. The establishment of additional program features and tiers of intervention will begin with program development and planning, recruitment, identification of community resources and partners, and the development of community outreach plans. This project will substantially expand hospital and community based programs, allowing far more children to be served.

Rationale

Nearly 34% of Travis county residents, 15% of which are children, live below 200% of the Federal Poverty Level (RHP #7 Community Needs Assessment, Full Report, July 2012), and 33% of Austin's children are overweight or obese. Travis County youth experience high rates of additional medical problems due to obesity. Obesity disproportionally affects children of color and children from low income families, and in underserved communities in Austin, rates of obesity are much higher, with up to 66% of school aged children overweight or obese (www.childrensoptimalhealth.org). Furthermore, projections estimate more than 4000 *morbidly* obese children (BMI ≥99th percentile) in Central Texas, (www.childrensoptimalhealth.org), resulting in massive current and future healthcare and social costs. According to recent data from the CDC, approximately 18% of 2-4 year olds in Travis County who are considered low income are already obese. This project option was selected because disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and patient empowerment tools. Disease management can help manage and improve the health status of a defined patient population over the entire course of a disease. With childhood obesity we can go one step further and move from a diseased state (e.g. obese) to a non-diseased state (normal weight), thus changing the trajectory for future negative health consequences. To address the core component of quality improvement, this project will integrate rapid cycle quality improvement activities, through weekly meetings, bi-annual progress report reviews, and 360° program evaluations. The project will also assemble a parent advisory council to provide additional guidance, feedback and suggestions. All program elements will be scalable as additional resources are identified. The metrics and milestones were selected so that we would best be able to track and report the progress and impact of this proposal. Many more children and families will be positively impacted by this proposal beyond those upon which we will formally track and report upon.

This project addresses several community needs identified in the *RHP #7 Community Needs Assessment:*

CN.2 – Inadequate access to specialty care.
CN.4 – Inadequate access to behavioral health care
CN.7 – Lack of coordination of care across settings of care; multiple conditions; and physical and behavioral health.
CN.9 - High rates of chronic disease such as: cardiovascular disease, cancer, rising rates of diabetes.
CN.10- Many residents have multiple chronic conditions
CN.11- Rising rates of physical inactivity and obesity.
CN.16- Lack of services for special populations such as children.
CN.17- Increasing diversity of the regions, exacerbating the existing racial and ethnic disparities across many health conditions.

Related Activities Funded by U.S. Dept. of Health and Human Services

This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives. Performing Provider, DCMC participates in the *Medicare and Medicaid Electronic Health Records* for hospitals; extension of this program to DCMC-affiliated physician offices and clinics is in development. DCMC is an awardee in an HHSC capital grant (HRSA-11-127) to add telecommunications and medical peripheral equipment to a pediatric mobile medical vehicle, but such services are not related to this project.

DCMC is also a sub-awardee for a research study awarded to University of Texas Health Science Center – Houston (Prime Award #1U18DP003367-01/Subaward #8773E for the study of childhood obesity; this contract does not duplicate or fund services provided through this intervention.

Related Category 3 Outcome Measure(s)

OD-9, Right Care, Right Setting
IT-9.4 Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (NQF #0024)[65]

Relationship to Other RHP Projects

This project is integrally linked to the chronic care management project for pediatrics (186599001.2.1). Program findings, outcomes and outcomes will be shared due to similar challenges in addressing families with obesity. We will also coordinate our efforts with our project to provide School Campus Counseling (186599001.1.1).

Dell Children's, the performing provider, has ensured that all project plans are based upon community needs and operate in conjunction with the RHP-wide initiatives. Furthermore, this proposed project meets the needs of the specific population and will not duplicate services of other performing providers' projects in the RHP.

Related projects in RHP 7 include:

201320302.2.2, the City of Austin's Community Diabetes Project, which works with similar target population, albeit an adult one, with obesity-related diagnoses.
307459301.2.1 - Community Care Collaborative - Patient-Centered Medical Home Project
307459301.1.1 - Community Care Collaborative - Implement/enhance and use chronic disease management registry functionalities

Related Category 4 Population Focused Measures: RD-1: Potentially Preventable Admissions

Plan for Learning Collaborative

Our providers will fully participate in RHP-wide learning collaboratives for projects that directly address chronic care management and improve broader community health, using technologies such as telephone and internet based interventions. Because of the wide scope of such services and the integration of care at all levels, we also plan to participate in learning collaboratives regarding care transitions, enhancement of interpretation services, culturally competent care and telemedicine. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas and solutions between providers will lead to more successful implementation and better outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically. Our proposal also includes an embedded learning collaborative for primary care providers to improve their care delivery and appropriate referrals regarding childhood obesity.

[65] National Committee for Quality Assurance (NCQA). HEDIS 2012: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2011

Project Valuation

Project valuation considered costs, cost avoidance, population impact, quality adjusted life years saved, patient experience, the overall impact to the community, as well as the project's ability to transform healthcare by providing the right care, at the right place, at the right time. This proposal is a far-reaching and ambitious project that will impact children on the individual, family, and community levels. It is expected to reduce the cost of preventable healthcare and future healthcare costs associated with obesity and the many medical problems that develop due to obesity. Maximum impact will be achieved by addressing childhood obesity, before many of these additional medical problems develop. Susan Combs, the Comptroller of the State of Texas, projects that the lifetime costs due to a child being obese is $500,000. Additionally, this project will improve the long-term quality of life for thousands of families. Healthy, active students will be able take full advantage of educational opportunities, as healthier children perform better in school and miss less school days. Entire households will understand obesity and its health consequences, eat more nutritiously, and become more active and fit individuals.

Additionally Addressing obesity among participants in the Medicaid program is particularly relevant. A 2006 study by Thompson Medstat[66] reviewed Medicaid claims data from 2004 and found that:

- Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance.
- Children treated for obesity are roughly three times more expensive for the health system than the average insured child.
- Annual healthcare costs are about $6,700 for children treated for obesity covered by Medicaid and about $3,700 for obese children with private insurance.
- The national cost of childhood obesity is estimated at approximately $11 billion for children with private insurance and $3 billion for those with Medicaid.
- Children diagnosed with obesity are two to three times more likely to be hospitalized.
- Children who receive Medicaid are less likely to visit the doctor and more likely to enter the hospital than comparable children with private insurance.
- Children treated for obesity are far more likely to be diagnosed with mental health disorders or bone and joint disorders than non-obese children.

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across

[66] Thompson Medstat. "Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions". 2006. http://www.medstat.com/pdfs/childhood_obesity.pdf 2

categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

186599001.2.1	***Project Option***: 2.7.5	***Project Components***: none required	2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.
Performing Provider: Dell Children's Medical Center			***TPI***: 186599001
Related Category 3 Outcome Measure(s):	*186599001.3.2*	***IT-9.4***	***Other Outcome Improvement Target:*** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 evidenced-based project to reduce and prevent obesity in children and adolescents Metric 1 [P-1.1] Document innovational strategy and plan to reduce and prevent obesity in children and adolescents Goal: Development written plan Data Source: Performing provider evidence of innovational plan **Milestone 1 Estimated Incentive Payment:** $1,039,849 **Milestone 2** [P-7]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should	**Milestone 3** [I-7]: Increase access to disease prevention programs using innovative project option. Metric [7.2]: Increase number of program participants (children and adolescents). Baseline: This is an expansion of a current program; baseline at end of DY2 is 160. Goal: 884 one-on-one encounters between program participants and a healthcare professional (e.g., physician, nurse, dietician, social worker, physical therapist, etc.). Data Source: patient medical records; registration records; participant records **Milestone 3 Estimated Incentive Payment:** $ 1,397,440 **Milestone 4** [P-7]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all	**Milestone 5** [I-7]: Increase access to disease prevention programs using innovative project option. Metric [7.2]: Increase number of program participants (children and adolescents). Baseline: This is an expansion of a current program; baseline at end of DY2 is 160 Goal: 864 additional one-on-one encounters between program participants and a healthcare professional (e.g., physician, nurse, dietician, social worker, physical therapist, etc.). Data Source: patient medical records; registration records; participant records **Milestone 5 Estimated Incentive Payment:** $1,306,933 **Milestone 6** [P-7]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning	**Milestone 7** [I-7]: Increase access to disease prevention programs using innovative project option. Metric [7.2]: Increase number of program participants (children and adolescents). Baseline: This is an expansion of a current program; baseline at end of DY2 is 160 Goal: 860 additional one-on-one encounters between program participants and a healthcare professional (e.g., physician, nurse, dietician, social worker, physical therapist, etc.). Data Source: patient medical records; registration records; participant records **Milestone 7 Estimated Incentive Payment:** $995,677 **Milestone 8** [P-7]: Participate in face to face learning (i.e. meetings or seminars) at least twice per year with other providers and the

186599001.2.1	***Project Option***: 2.7.5	***Project Components***: none required	2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.
Performing Provider: Dell Children's Medical Center			***TPI***: 186599001
Related Category 3 Outcome Measure(s):	*186599001.3.2*	***IT-9.4***	***Other Outcome Improvement Target:*** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
publicly commit to implementing these improvements. Metric 1 [P.7.1:] Number of semi-annual meetings, calls or webinars held by RHP #7. Goal: Participate in face to face learning (i.e. meetings or seminars) at least twice per year Data Source: Documentation of semi-annual meetings including agendas, slides from presentation and/or meeting notes. **Milestone 2 Estimated Incentive Payment:** $ 1,039,849	providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P.- 7.1:] Number of semi-annual meetings, calls or webinars held by RHP #7. Goal: Participate in face to face learning (i.e. meetings or seminars) at least twice per year Data Source: Documentation of semi-annual meetings including agendas, slides from presentation and/or meeting notes. **Milestone 4 Estimated Incentive Payment:** $ 1,397,440	around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P.-7.1:] Number of semi-annual meetings, calls or webinars held by RHP #7. Goal: Participate in face to face learning (i.e. meetings or seminars) at least twice per year Data Source: Documentation of semi-annual meetings including agendas, slides from presentation and/or meeting notes. **Milestone 6 Estimated Incentive Payment:** $ 1,306,933	RHP to promote collaborative learning around shared or similar projects. At each face to face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Metric 1** [P.-7.1:] Number of semi-annual meetings, calls or webinars held by RHP #7. Goal: Participate in face to face learning (i.e. meetings or seminars) at least twice per year Data Source: Documentation of semi-annual meetings including agendas, slides from presentation and/or meeting notes. **Milestone 8 Estimated Incentive Payment:** $995,677

186599001.2.1	***Project Option***: 2.7.5	***Project Components***: none required	2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.
Performing Provider: Dell Children's Medical Center			***TPI***: 186599001
Related Category 3 Outcome Measure(s):	*186599001.3.2*	***IT-9.4***	***Other Outcome Improvement Target:*** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $2,079,698	**Year 3 Estimated Milestone Bundle Amount:** $2,794,880	**Year 4 Estimated Milestone Bundle Amount:** $ 2,613,866	**Year 5 Estimated Milestone Bundle Amount:** $ 1,991,354
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $9,479,798			

DELL CHILDREN'S MEDICAL CENTER (DCMC)
Chronic Care Management - Pediatrics
PROJECT ID: 186599001.2.2 PASS 1

Provider: DCMC is the only Children's Hospital in the region and operates the only Level 1 Pediatric Trauma Center in Central Texas. Austin proper has a population of approximately 820,000 and is located in Travis County, with a population of approximately 1.1 million. The hospital has 176 beds is part of a larger health care system, Seton Healthcare Family, through which it has access to an extensive network for primary, specialty, and emergency care.

Intervention(s): This project expands a pilot project started in DY1 to create an outpatient clinic to deliver comprehensive, integrated primary and specialty care to manage the care of children with a very high disease complexity and high utilization of services. At the end of the demonstration, the project will operate four (4) medical homes for medically fragile children.

Need for the Project: There is an extreme lack of coordination of care for children with complex chronic diseases. Medically fragile children with complex chronic diseases are particularly vulnerable because their conditions can deteriorate rapidly and result in permanent injury or death. This project will include services such as palliative care, behavioral medicine and psychiatric care embedded in the care structure in a manner that affirms the family as a unit of concern and designs processes that maximize "well days" for the entire family unit (CN.7). Better management of care will reduce costs related to lengthy hospital stays, hospital admissions and ED utilization.

Target Population: This project seeks to serve children with a very high disease complexity; 1-3% of the pediatric population. These children typically have a serious, prolonged illness or chronic condition that requires daily medical treatment and monitoring. This small subset of pediatric patients may account for up to 40% of all pediatric dollars. Project estimates 75%-80% are Medicaid eligible.

Category 1 or 2 Expected Patient Benefits: The project will provide chronic care management of highly complex diseases for a total of 1,000 children. The project served 150 children and adolescents in DY1 (baseline) and by the end of each demonstration year will increase enrollment into the program as follows:

	Additional Patients	Total Number Served
DY2	150	150
DY3	200	350
DY4	300	600
DY5	400	1000

Please note that we expect a portion of program enrollees to leave the program and return in a subsequent year due to fluctuations in a patient's acuity level and/or eligibility criteria for the program; a re-enrollment will be counted as a new enrollment.

Category 3 Outcomes: IT-9.2 The project seeks to reduce the number of pediatric ED visits by program enrollees 20% below baseline in DY4 and by 30% below baseline in DY5. Baseline to be determined in DY3.

Project Title: Chronic Care Management - Pediatrics

Protect Option: 2.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.

Unique Project ID: 186599001.2.2 Pass 1

Performing Provider Name: Dell Children's Medical Center

TPI: 186599001

Project Description

Dell Children's Medical Center proposes to expand a pilot to manage the comprehensive care of children with complex, chronic disease in the outpatient setting.

The purpose of the Care Management for Chronically Ill Children and Adolescents project is to identify and manage a population of children with very high disease complexity and multiple co-morbid conditions to deliver comprehensive integrated care that can improve outcomes and reduce costs. The target population medically fragile children with a serious or prolonged illness or conditions, - often congenital neurological and metabolic disorders, with associated cognitive impairment and multisystem involvement. Their conditions can deteriorate rapidly and result in permanent injury or death and require daily medical treatment and monitoring. Often a specialized medical device or assistive technology is used to compensate for the loss of a body function, such as an enteral feeding tube, total parenteral feeding tube or used for cardiorespiratory monitoring, oxygen support, and other types of assistance imposed by tracheotomy, colostomy, Ileostomy, or other medical, surgical procedures. Families of children with complex chronic condition are financially vulnerable. In our original pilot we have observed that three-fourths of the patients are on Medicaid either because of poverty or because of SSI disability benefits.

There is an extreme lack of coordination of care for children with complex chronic diseases. Medically fragile children are particularly vulnerable because their multisystem involvement requires treatment by a variety of medical subspecialists, e.g. pediatric gastroenterologist or pediatric neurologist. As a result, subspecialist input is often lost in the shuffle. PCPs are marginalized with a resultant loss of competency. Parents are intimidated and are unable to understand and take ownership of the care plan. The proposed model creates an outpatient clinic to deliver comprehensive integrated primary and specialty care to these children. Multidisciplinary services such as palliative care, behavioral medicine and psychiatric care are embedded in the care structure in a manner that affirms the family as a unit of concern and designs processes that maximize "well days" for the entire family unit.

The goals of this project are therefore:

1. Embed subspecialist services and utilize strategies such as evidence-based protocols and group visits to improve quality and efficiency.
2. Design and implement an integrated, comprehensive system of care that leads to a substantial improvement of patient and family satisfaction as measured in patient satisfaction survey (CAHPS).

3. Decrease preventable hospitalizations and reduce ED utilization.

The clinic will be staffed by a core team led by a pediatrician and an advanced practice nurse, a case manager, a social worker and a child life specialist. The clinic utilizes subspecialists not just for direct patient care but for competency building activities such as case reviews and protocol development. In addition, a family liaison will develop a parent advisory panel and community outreach. A community health worker will be hired at each site to serve as a 'social worker extender' and help families navigate the health care system.

This project will define a population of children based on 'complexity'. It will standardize processes for coordination, information-sharing, care plan creation and transition to adulthood. To allow effective implementation, the project will utilize technology such as a robust EMR with a patient portal, telemedicine to allow remote consultation with specialists and patients and robust data repositories and registries to track outcomes.

Implementing a change in this new delivery of care is the provider's biggest challenge. The proposed project is a significant departure from the current organization of services and will require diligent training and constant commitment of all the stakeholders to avoid defaulting back to the old system. The old system is primarily 'transactional' and relies on a discrete encounter to deliver services. The proposed model is 'relational' and engages the patient and family longitudinally. As a result, non physician members such as social workers and community health workers will play a more significant role in delivering care. We anticipate defining the roles of each team member to deliver quality care most efficiently may be challenging given the traditional reimbursement schemes. Utilizing subspecialists as consultants will also require novel processes to be developed. We will ~~be utilized to~~ design, evaluate and adjust each process on a continuous basis to make sure the desired goals are achieved.

This project addresses the following RHP 7 Goals:
RHP Goal #2. *Reduce Health System costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.* By replacing the old fragmented system, this clinic is will be the central place where all clinical decisions are implemented. In addition to enhanced care coordination, the clinic will utilize subspecialty services by a variety of mechanisms. For example, Pediatric neurologists will co-locate at the clinic twice a month to review and manage the care of children with intractable epilepsy who are on the ketogenic diet. A child psychologist, a child psychiatrist and a pediatric rehab medicine physician are embedded in the clinic and will direct the care in their respective areas of expertise.
RHP Goal #3. *Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.* Successful implementation of this project will allow the RHP to have a carefully tested care delivery model for this population.
RHP Goal #4. *Bolster individual and population health by improving chronic disease management.* The processes that are being put in place for this project and the technology infrastructures that will be implemented– such as telemedicine, implementation of EMR with robust documentation for tracking outcomes etc. will serve as templates for other chronic disease management projects in the RHP.
RHP Goal #6 : *Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services that promote recovery.* The clinic is designed to embed the services of a child psychologist and a child psychiatrist to help in the management of mental health co-morbidities that

are prevalent in this population. These include autism, aggression, self-injurious behavior and ADHD. By co-locating these subspecialist services in the same primary care clinic the RHP goal to provide timely, effective behavioral health services will be realized.
RHP Goal #7. *Improve the patient experience of care by increasing the quality of care and patient safety.* This project will define a population of children on the basis of 'complexity'. It will identify points at which the child and family touch the system and standardize processes for coordination, information-sharing, care plan creation and transition to adulthood. Patient satisfaction will be surveyed at each point and improvements instituted on an on-going basis.

Starting Point/ Baseline

The project expands a pilot project started in January 2012 (DY1)to determine cost-effectiveness of this model for 150 children with very high complexity and high utilization of services. The baseline is 150 patients. The process of delivering care for the first 150 families will inform the design of a high quality, effective care delivery system that will be scaled for implementation in other primary care practices in the community. At the end of five years, the project will operate four medical homes for children with medical complexity and serve at least 1000 patients.

Rationale

The Project Option selected is "Redesign the Outpatient delivery system to coordinate care for patients in chronic diseases". There is very compelling evidence in the literature that shows the current encounter-based model is fragmented and haphazard and ill suited for longitudinal management of patients with chronic conditions. The deficiencies of the current system are more compounded in patients who have multiple chronic conditions.

In Pediatrics, advances in medical technology and more effective treatment for life limiting illness have allowed children with Complex Chronic Conditions to survive not only the neonatal period but also their adolescent years, with an ever-increasing number living well into adulthood. The resulting complexity of care increases the burden to their families. Families depend on the expertise of pediatric subspecialists, therapists, medical device vendors, mental and behavioral health professionals, and special education programs in schools, for medical and parenting guidance as they attempt to provide a measure of quality to the life of these children.

In Texas, according to a 2011 census estimates (http://quickfacts.census.gov/qfd/states/48/48453.html) Travis County is home to roughly 254,088 children (1). The most medically fragile 1-3% of these children are the targets of this intervention.

Core components of the project will be addressed as follows:

a. *Design and Implementation of care teams tailored to patient health care needs, including non-physician health professionals and health coaches helping patients and caregivers navigate the healthcare system.* A high-functioning core team of staff will be organized with careful role definition to allow each individual to perform at the 'top' of their license. The Pediatrician, as a team lead will be responsible for gathering input from the different subspecialists and putting together the care plan. The Advanced Practice Nurse actively implements the clinical aspects of the care plan. Other professionals, specifically, the case manager, social worker and child life specialists implement other aspects of the plan (care coordination, system navigation, outreach to schools,

respectively). The clinic will utilize the full breadth of subspecialist services efficiently through mechanisms that include - direct visits, evidence-based protocol development, case reviews with the core team and facilitation of workshops for parents.

b. *Ensure Patients (or their caregiver) can access their care teams in person or by phone or by e-mail.* Activities planned include provision of 24/7 access by phone, Saturday morning clinics for urgent problems and a patient portal that allows secure two-way communication between families and providers. In addition, for very fragile children such as patients who are on home ventilation and tracheostomy that require transport by ambulance for office visits, telemedicine consultation or home visits will be provided.

c. *Increase Patient Engagement:* Parents and Families are invited to participate in the design and continuous improvement of the care delivery model through a 'Parent Advisory Panel'. Support groups will be encouraged and facilitated through the Clinical Social Worker. Integration with schools is achieved though the work of the child life specialist. The community health worker ('health coach') provides health education, support, advocacy and outreach to community resources.

d. *Implement Patient Empowering Initiative:* In this population of children with multiple co-morbidities and complicated medical regimens, we will work with community health workers to provide families with tools that help them organize the care. For example, an "All About Me" binder will be provided that has an easy to understand list of the medication regimen and care plan with appropriate care to primary language and literacy level of the families. At every level of the care, shared decision making is fostered. As many of these children have life-limiting conditions, embedded palliative care will provide support and encouragement to families at the most difficult periods of their children's lives.

e. *Conduct Quality Improvement* Activities for process improvement will be instituted at every level. These include workflow efficiencies, tracking frequency of use of standardized treatment protocols, tracking of preventable emergency department visits and hospitalizations. PDSA cycles help identify lessons learnt and analyze opportunities for improvement.

This project addresses several community needs identified in the RHP:

- CN.2 – Inadequate access to specialty care
- CN.4 – Inadequate access to behavioral health care
- CN.7 – Lack of coordination of care across settings of care; multiple conditions; and physician and behavioral health.
- CN.10- Many residents have multiple chronic conditions
- CN. 16- Lack of services for special populations

Related Activities Funded by U.S. Dept. of Health and Human Services

This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives. Performing Provider, DCMC participates in the *Medicare and Medicaid Electronic Health Records* for hospitals; extension of this program to DCMC-affiliated physician offices and clinics is in development; participation in the EHR program is expected to support the care delivered under this project and coordination between providers.

Related Category 3 Outcome Measures

OD-9: Right Care, Right Setting: IT-9.2 ED appropriate utilization.
This outcome measures cost effectiveness as well as the effectiveness of preventive services (example –flu immunization) and timely, in-clinic intervention for inter-current illnesses. We seek to reduce preventable ED visit. In addition, we will track the number of patients who go to the ED without a referral and hope to decrease that number continuously. We will use the patient's as their own historical controls and compare ED visit rates in the years before starting care in this model and the years after.

Each component of the model – i.e patient empowerment, 24/7 access, same-day appointment for inter-current illnesses, integrated subspecialist care, evidence-based protocols all contribute to better outcome and an increased number of "well days" for the patient and the family. ED utilization is likely to decrease as a result of each of the services listed above.

Relationship to Other Projects RHP Projects

Dell Children's has ensured that all project plans are based upon community needs and operate in conjunction with the RHP-wide initiatives. Furthermore, this proposed project meets the needs of the specific population and will not duplicate services of other Dell projects in the RHP, although all Dell Children's projects focus on Pediatric patients. These are: 186599001.1.1, School Campus Counseling & 186599001.2.1, Family and Child Obesity.

Related projects performed by other providers in RHP 7 are:
133542405.2.5 - Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults
307459301.2.3 - Integrated Behavioral Health Intervention for
137265806.2.5 Care Transitions
137265806.2.6 - Chronic Care Management: Adults
137265806.1.4 - Language Services Resource Center
137265806.1.5 - Culturally Competent Care Training

Related Category 4, population-Improvement measures (based on hospital data) are:

- Domain 1 – Potentially Preventable Admissions
- Domain 2 – Potentially Preventable Readmissions

Relationships to Other Projects & Plan for Learning Collaborative

Provider will fully participate in RHP-wide learning collaboratives for projects that directly address chronic care management which will be submitted in Pass 2. Additionally, because of the wide scope of such services and the integration of care, plans to participate in learning collaboratives regarding childhood obesity, care transitions, enhancement of interpretation services, culturally competent care, and telemedicine are expected. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers will be conducted in-person, by teleconference or electronically.

Project Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

This Chronic Care Management Model for Children and Adolescents presents a significant opportunity to manage chronic healthcare conditions effectively at specialty care level without compromising quality. Our target population constitutes the top 1-3% of the pediatric population that has complex chronic conditions. The cohort will be largely derived from pediatric subspecialty and children's hospital intermediate care unit databases – and we believe will likely constitute the most complex top 1% of the Pediatric population. Although the target population constitutes only 1-3% of the pediatric population, many studies have shown that they account for 40% of pediatric dollars.[67][68] A 2010 study of 400 DCMC inpatients with multiple co-morbid conditions incurred costs of over $87M. Graphics below illustrate a significant spike in inpatient costs and ED visits as the number of co-morbid conditions increase.

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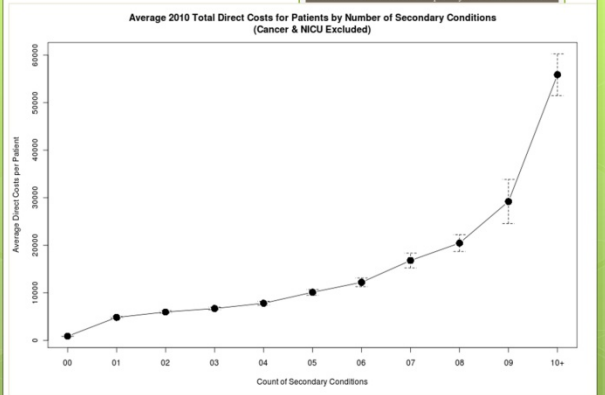
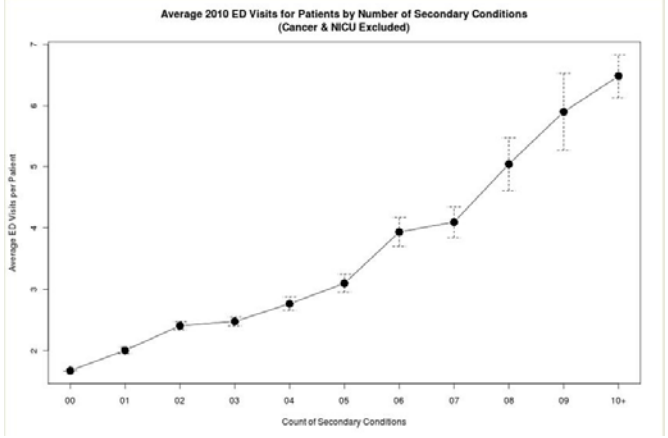
[67] In a 2001 study conducted by the Kaiser Foundation, the top 1% of enrollees accounted for over 25.7% of Medicaid expenditures. A study by Johns Hopkins University (1996) for the Health and Human Services that looked at the cost of care for Medicaid enrolled children with selected disabilities found that 10% of the group accounted for 70% of total expenditures. It also showed that increasing complexity as measured by the number of co-morbid conditions led to increase costs. In this study mean (annual) costs – excluding inpatient costs with two conditions were $17,569, but for those with three conditions the mean was $47,153.

[68] The Children with Special Health Care Needs (CHSCN) group constitutes 16-18% of the pediatric population and includes children with all chronic conditions (including ADHD, asthma, obesity). Cost and utilization data for the CHSCN population shows much higher utilization and expenditures such as three times as many hospitalizations and seven times as many hospital days. However, this data is based on the 16-18% of the pediatric population and does isolate the top 1-3% with a higher acuity and number of co-morbidities. http://childhealthdata.org/docs/cshcn/0506_cshcn-spss_final_508-pdf.pdf)

Analysis of inpatient data at our own children's hospital (Dell Children's Medical Center) shows the association of increased complexity with increased cost





UNIQUE IDENTIFIER: 186599001.2.2	RHP PP REFERENCE NUMBER 2.2.1	PROJECT COMPONENTS: 2.2.1(A-E)	PROJECT TITLE: CHRONIC CARE MANAGEMENT FOR CHRONICALLY ILL CHILDREN AND ADOLESCENTS 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.	
Performing Provider: Dell Children's Medical Center				**TPI: 186599001**
Related Cat 3 Outcome Measure:	186599001.3.3	**IT 9.2**	**ED Appropriate Utilization**	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of comprehensive care management program. **Goal:** Produce a written care management program **Data Source**: Program documentation; literature on chronic disease management models **Milestone 1: Estimated Incentive Payment:** $1,062,457 _____ **Milestone 2** [I-17]: Apply the chronic care model to targeted chronic diseases which are prevalent locally. Metric 1 [I-17.1]: Number of additional patients receiving care under the Chronic Care Model a chronic disease or multiple chronic diseases. Baseline: 150 unique patients enrolled in program in DY1.	**Milestone 4** [I-17]: Apply the chronic care model to targeted chronic diseases which are prevalent locally. Metric 1 [I-17.1]: Number of additional patients receiving care under the Chronic Care Model a chronic disease or multiple chronic diseases. Baseline: 150 unique patients enrolled in program in DY1. Goal: Increase enrollment by 200 patients (cumulative program enrollment 350). Data Source: Program registry; Patient records **Milestone 4: Estimated Incentive Payment:** $1,793,694 2 _____ **Milestone 5** [P-6]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.6-1:] Participate in semi-annual face-to-face meetings or		**Milestone 6** [I-17]: Apply the chronic care model to targeted chronic diseases which are prevalent locally. Metric 1 [I-17.1]: Number of additional patients receiving care under the Chronic Care Model a chronic disease or multiple chronic diseases. Baseline: 150 unique patients enrolled in program in DY1. Goal: Increase enrollment by 300 patients (cumulative program enrollment 600). Data Source: Program registry; Patient records **Milestone 6: Estimated Incentive Payment:** $2,019,415 _____ **Milestone 7** [P-6]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.6-1:] Participate in semi-annual face-to-face meetings or	**Milestone 8** [I-17]: Apply the chronic care model to targeted chronic diseases which are prevalent locally. Metric 1 [I-17.1]: Number of additional patients receiving care under the Chronic Care Model a chronic disease or multiple chronic diseases. Baseline: 150 unique patients enrolled in program in DY1. Goal: Increase enrollment by 400 patients (cumulative program enrollment 1000). Data Source: Program registry; Patient records **Milestone 8: Estimated Incentive Payment**: $1,800,212 _____ **Milestone 9** [P-6]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.6-1:] Participate in semi-annual face-to-face meetings or

UNIQUE IDENTIFIER: 186599001.2.2	RHP PP REFERENCE NUMBER 2.2.1	PROJECT COMPONENTS: 2.2.1(A-E)	PROJECT TITLE: CHRONIC CARE MANAGEMENT FOR CHRONICALLY ILL CHILDREN AND ADOLESCENTS 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.	
Performing Provider: Dell Children's Medical Center				**TPI: 186599001**
Related Cat 3 Outcome Measure:	186599001.3.3	**IT 9.2**	**ED Appropriate Utilization**	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Goal: Increase enrollment by 150 patients (cumulative program enrollment 150). Data Source: Program registry; Patient records **Milestone 2: Estimated Incentive Payment:** $1,062,457 **Milestone 3** [P-6]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.6-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. **Milestone 3: Estimated Incentive**	seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. **Milestone 5 4 Estimated Incentive Payment:** $1,793,691	seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. **Milestone 7: Estimated Incentive Payment:** $2,019,415	seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. **Milestone 9: Estimated Incentive Payment:** $1,800,212	

UNIQUE IDENTIFIER: 186599001.2.2	RHP PP REFERENCE NUMBER 2.2.1	PROJECT COMPONENTS: 2.2.1(A-E)	PROJECT TITLE: CHRONIC CARE MANAGEMENT FOR CHRONICALLY ILL CHILDREN AND ADOLESCENTS 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases.
Performing Provider: Dell Children's Medical Center			**TPI: 186599001**
Related Cat 3 Outcome Measure:	186599001.3.3	**IT 9.2**	**ED Appropriate Utilization**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Payment: $1,062,457			
Year 2 Estimated Milestone Bundle Amount: $3,187,371	**Year 3 Estimated Milestone Bundle Amount: $3,587,383**	**Year 4 Estimated Milestone Bundle Amount: $4,038,830**	**Year 5 Estimated Milestone Bundle Amount: $3,600,424**

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Category 2 DSRIP Projects

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Hays County Mental Health Center Integrated Care
133340307.2.1 Pass 1

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will integrate primary care into the Hays County Mental Health Clinic as a means to address integrating primary and behavioral health care for individuals with Severe and Persistent Mental Illness. The project will enable individuals being treated for Severe and Persistent Mental Illness to have a Health Home at the Hays County Mental Health Center where they can receive both their psychiatric and physical health care thus avoiding potentially preventable admissions to hospitals and reduce emergency department utilization.

Need for the project: Research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population. . Between 2006 and 2010, Hays County residents with a diagnosis of mental illness accounted for 244 hospital days per year for potentially preventable admissions related to diabetes and hypertension. Hill Country MHDD Centers plans to integrate primary care into the Hays County Mental Health Clinic as a means to address this issue.

Target population: The target population includes individuals within Hays County who have a psychiatric diagnosis and receive mental health treatment at the Hays County Mental Health Clinic and who have risk factors associated with diabetes and/or hypertension. Based on the population served in Hill Country's existing behavioral health program in RHP 7, it is anticipated that approximately 30% of our patients within RHP 7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The goal of this project is to provide Integrated Behavioral Health and Primary Care at the Hays County Mental Health Clinic. The project will enable individuals being treated for Severe and Persistent Mental Illness to have a Health Home at the Hays County Mental Health Center where they can receive both their psychiatric and physical health care in order to avoid preventable hospital admissions and reduce emergency department utilization. By Demonstration Year 5, the goal is to have a minimum of 200 individuals receiving both Psychiatric and Physical Health care at the Hays County Mental Health Clinic (number of behavioral health clients beginning receipt of Integrated Care by DY: DY3 40; DY4 60; and DY5 100).

Category 3 outcomes: IT-10.1 Quality of Life/Functional Status (SF-12). Our goal is to have, at a minimum, 15% of the individuals receiving integrated care services showing improvement on the SF-12 which demonstrates better physical function thus reducing the need for inpatient hospitalization, inappropriate ED use and incarceration.

Title of Project: Hays County Mental Health Center Integrated Care

Category / Project Area / Project Option: 2.15 Integrate Primary and Behavioral Health Care Services 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services

RHP Project Identification Number: 133340307.2.1 Pass 1

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

Hill Country MHDD Centers plans to integrate primary care into the Hays County Mental Health Clinic as a means to address integrating primary and behavioral health care for individuals with Severe and Persistent Mental Illness. Between 2006 and 2010, Hays County residents with a diagnosis of mental illness accounted for 244 hospital days per year for potentially preventable admissions related to diabetes and hypertension. Interventions will be designed to specifically identify and address the potentially preventable admissions of diabetes and hypertension with a co-occurring diagnosis of mental illness. The project will enable individuals being treated for Severe and Persistent Mental Illness to have a Health Home at the Hays County Mental Health Center where they can receive both their psychiatric and physical health care. By Demonstration Year 5, the goal is to have a minimum of 200 individuals receiving both Psychiatric and Physical Health care at the Hays County Mental Health Clinic.

National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without those disorders. In addition, individuals with diagnosed psychiatric disorders are less likely to receive preventive medical services than the general population. In *Barriers to Primary Medical Care Among Patients at a Community Mental Health Center,* published in Psychiatric Services in 2003, the study found that two-thirds of individuals with severe mental illnesses served in a community mental health clinic were unable to name a primary care provider, with many reporting either no routine physical health care or use of the emergency department as their primary source of care.

Research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness. The Hays County Mental Health Clinic serves over 1,000 adults annually with 75.22% having incomes below $15,000 and 93.29% having incomes below $30,000. This coupled with the fact that Hays County is a designated Health Professional Shortage Area for Primary Medical Care for low income individuals emphasizes the need for primary care services for individuals with Severe and Persistent Mental Illness in Hays County.

Challenges:

A local corporation has donated a new facility that is currently under construction that will allow for the space to provide integrated care in the Hays County Mental Health Clinic. The primary challenge remaining is identifying and recruiting a primary care physician and staff dedicated to working with individuals with Severe and Persistent Mental Illness. Hill Country will address the challenge by offering incentives as necessary.

Project Goals

The goal of this project is to provide Integrated Behavioral Health and Primary Care at the Hays County Mental Health Clinic. The project will enable individuals being treated for Severe and Persistent Mental Illness to have a Health Home at the Hays County Mental Health Center where they can receive both their psychiatric and physical health care. By Demonstration Year 5, the goal is to have a minimum of 200 individuals receiving both Psychiatric and Physical Health care at the Hays County Mental Health Clinic.

How the Project is Related to RHP Goals

Goal 2 - Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Goal 3 - Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

Starting Point/Baseline

Baseline Data Currently no integrated primary care services are available at the Hays County Mental Health Clinic

Reason for Selection of Project Options and Components

Hill Country MHDD Centers plans to integrate primary care into the Hays County Mental Health Clinic as a means to address this issue. Interventions will be designed to specifically identify and address the potentially preventable admissions of Diabetes, and Hypertension with a secondary diagnosis of mental illness identified above. The project will enable individuals being treated for Severe and Persistent Mental Illness to have a Health Home at the Hays County Mental Health Center where they can receive both their psychiatric and physical health care. By Demonstration Year 5, the goal is to have a minimum of 200 individuals receiving both Psychiatric and Physical Health care at the Hays County Mental Health Clinic.

In designing a program to address the primary care needs of individuals with Severe and Persistent Mental Illness and unaddressed primary care needs, Hill Country MHDD Centers will:

I) *Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.* Hill Country will analyze the demographics of the population served at the Hays County Mental Health Clinic to determine the number of individuals who do not have a primary care physician and do not regularly receive primary care services outside of the emergency department.

J) *Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.* Hill Country will work with appropriate legal and clinical counsel to develop necessary agreements for co-scheduling and sharing of information between health care providers in order to fully create an environment of integrated care.

K) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers. Hill Country will develop protocols to identify and refer individuals served at the

Hays County Mental Health Clinic that would benefit from primary care services at the clinic, especially individuals at risk of diabetes or hypertension. In addition, Hill Country will work with primary and behavioral health clinicians to develop appropriate process for communication, data-sharing and referral between providers.

L) *Recruit a number of specialty providers to provide services in the specified location.* Hill Country will identify the appropriate staffing level for incorporating primary care services into the Hays County Mental Health Clinic and recruit through advertisement and formal letters for the necessary providers for primary care services.

M) *Train physical and behavioral health providers in protocols, effective communication and team approach.* Hill Country will build a shared culture of treatment and formalized meetings and procedures focused on regular consultative meetings between disciplines, case conferences between disciplines, and shared treatment plans co-developed by both physical health and behavioral health practitioners.

N) *Acquire data reporting, communication and collection tools to be sued in the integrated setting.* Hill Country will make necessary adjustments to EHRs to incorporate primary care services and planning in the patients records and utilize other means to collect service information until EHRs can be adjusted appropriately.

O) *Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.* Hill Country will continually review with clinicians and legal counsel any necessary legal agreements that may be needed in a collaborative practice and will review similar agreements from other successfully implemented programs.

P) *Arrange for utilities and building services for these settings.* Hill Country has been fortunate in having a local company that is building a new facility that will have the space and capacity to incorporate physical health staff with behavioral health staff.

Q) *Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.* Hill Country will determine the necessary software adjustments needed to track and report on integrated services and the outcomes they provide. Until such time as the software changes can be made, Hill Country will develop other electronic methods, utilizing Excel or database software, to track services and outcomes.

R) *Conduct quality improvement for project using methods such as rapid cycle improvement.* Hill Country will conduct regular meetings, either monthly or quarterly, between behavioral health clinicians, primary care clinicians, and quality management staff to gain feedback on what is working and where adjustments need to be made. In addition, meetings will incorporate feedback from patients utilizing the integrated care services.

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals beginning service to ensure the project is operational during DY3. DY4 and DY5 have new patients beginning integrated care and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique Community Need Identification Number

CN7 Lack of coordination of care across settings of care, multiple conditions, and physical and behavioral health

CN8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions.

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

The Hays County Mental Health Center does not currently offer physical health care for patients.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-10 Quality of Life/Functional Status
IT-10.1 Quality of Life-SF-12

Reasons/Rationale for Selecting the Outcome Measure(s)
The SF-12 acquires the individual's overall views about their health, physical and mental, and will be able to demonstrate improvement of individuals receiving both behavioral health and physical health care. In the AIMS Integrated Behavioral Health Care in the Era of the Medical Home study in 2011 the SF-12 showed increased improvement in better physical function as individuals received ongoing integrated care.

Relationship to Other RHP Projects

Provision of Mental Health First Aid and Trauma Informed Training coupled with the provision of trauma based services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services and 1333040307.4 Trauma Informed Care) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*
133340307.2.2 - IDD Mental Health Crisis Center
133340307.2.3 - Co-occurring Psychiatric and Substance Use Disorder Services
1333040307.4 - Trauma Informed Care

List of Related Projects from other RHP 7 Providers
133542405.2.5 - Austin Travis County Integral Care - Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults
126844305.2.4 - Bluebonnet Trails Community Services - Design, implement, and evaluate project that provides integrated primary and behavioral health care services: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County
307459301.2.3 - Community Care Collaborative - Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients
137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department
137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation
137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation
307459301.1.3 - Community Care Collaborative - Mobile Primary Care

List of Related Category 4 Projects: *N/A*

Relationship to Other Performing Providers' Projects in the RHP

Central Texas Medical Center's proposal for Expanding Primary Care Capacity for Low-Income Residents of Hays County, TX (121789503.1.1) may have a similar target population.

Other Performing Providers' projects with similar interventions or target populations include ATCIC's Integrate Primary and Behavioral Health Care Services (133542405.2.1) and the City of Austin's Expansion of Community Diabetes Project (201320302.2.2).

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provides mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap.

Plan for Learning Collaborative

Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve

services and data collection and to identify how to address additional needs that may arise. Hill Country MHDD Centers will participate in a learning collaborative that meets at least annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The valuation on this project is based on an estimated 200 individuals receiving primary health care over the life of the project.

133340307.2.1	***2.15***	***2.15.1 A-I***	Hays County Mental Health Center Integrated Care
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*1133340307.3.1*	*IT-10.1*	*Quality of Life SF-12*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 and providers participating in the integration project Metric 1 P-5.2: Number of primary care providers newly located in behavioral health setting Baseline/Goal: Baseline 0, Goal 1 Data Source: Employment data/contract agreement Milestone 1 Estimated Incentive Payment *(maximum amount):* $750,000	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Hays County Mental Health Integrated Care) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 40 individuals beginning service during DY3 **Data Source**: Hill Country	**Milestone 3 P-7**: Evaluate and continuously improve integration of primary and behavioral health services Metric 1 P-7.1]: Project planning and implementation of documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 3 Estimated Incentive Payment: $395,248.50	**Milestone 5 P-7**: Evaluate and continuously improve integration of primary and behavioral health services Metric 1 P-7.1]: Project planning and implementation of documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 5 Estimated Incentive Payment: $404,346

133340307.2.1	***2.15***	***2.15.1 A-I***	Hays County Mental Health Center Integrated Care	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*1133340307.3.1*	*IT-10.1*	*Quality of Life SF-12*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $782,410**		**Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Hays County Mental Health Integrated Care) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 60 individuals beginning service during DY4(for a total of 100) **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $395,248.50**	**Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Hays County Mental Health Integrated Care) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 100 individuals beginning service during DY5(for a total of 200) **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $404,346**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $750,000	Year 3 Estimated Milestone Bundle Amount: $782,410		Year 4 Estimated Milestone Bundle Amount: $790,497	Year 5 Estimated Milestone Bundle Amount: $808,692
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,131,599				

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Hays County Mental Health/Intellectual & Developmental Disability Crisis Center
133340307.2.2 Pass 1

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): The goal of this project is to develop a crisis center for individuals dually diagnosed with mental illness and intellectual and developmental disabilities who are in a behavioral health crisis in order to provide temporary emergency respite for the individual and behavioral assessment to determine cause and provide appropriate interventions, such as Cognitive Adaptation Therapy, for the individual to reduce the recurrence of the crisis in the future, and establish community supports to maintain the individual in a community setting instead of in a hospital, emergency room, nursing home, or institutional care.

Need for the project: Within the past year there have been 44 instances identified where consumers would have benefited from a crisis center for individuals dually diagnosed with IDD and mental health but instead entered the Emergency Departments, psychiatric hospital, criminal justice system or state supported living centers.

Target population: The target population includes individuals dually diagnosed with mental illness and intellectual and developmental disabilities within Hays County in RHP7 as well as the other 18 counties in Hill Country's service area (Bandera, Blanco, Comal, Edwards, Gillespie, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde). Based on the population served in Hill Country's existing intellectual and developmental disability program in RHP 7, it is anticipated that approximately 84% of our patients have Medicaid and approximately 86% have income below $15,000 per year. We expect the target population will be similar to this.

Category 1 or 2 expected patient benefits: The project aims to establish a mental health/intellectual and developmental disability crisis center in a community setting within Hays County in RHP 7 which will reduce inappropriate ED use and incarceration. The project seeks to provide services to a minimum of 100 individuals from Hill Country's service area including Hays County in RHP 7 by the end of DY5 (number beginning service by DY: DY3 15; DY4 30; and DY5 55)

Category 3 outcomes: IT-10.7 Quality of Life/Functional Status Other Outcome Improvement Target – Supports Intensity Scale
Our goal is to have, at a minimum, 20% of the individuals served by the mental health/intellectual and developmental disability crisis center showing improvement on the Supports Intensity Scale which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, inappropriate ED use and incarceration.

Title of Project: **Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Hays County Mental Health/Intellectual & Developmental Disability Crisis Center**

Category / Project Area / Project Option: 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

RHP Project Identification Number: 133340307.2.2 Pass 1

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

Hill Country plans to develop a crisis response center for individuals with Intellectual and Developmental Disabilities and a co-occurring Behavioral Health disorder that will provide temporary emergency respite for the individual and behavioral assessment to determine cause and appropriate interventions, such as Cognitive Adaptation Therapy, for the individual to reduce the recurrence of the crisis in the future. Since individuals with Intellectual and Developmental Disabilities and Psychiatric issues have less ability to adjust between a community setting and an institutional setting, it is anticipated that the facility will be set up similar to a group home environment with more intensive staff to consumer ratios and with staff that have additional training in Applied Behavioral Analysis. By maintaining the individuals in the community the individual is not traumatized by going to a foreign setting that does not specialize in treating their diagnosis. The crisis center will serve Hays County in RHP7 as well as the other 18 counties in Hill Country's service area (Bandera, Blanco, Comal, Edwards, Gillespie, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde). In reviewing information over the past year, there have been 44 instances identified where consumers would have benefited from such a center but instead entered the Emergency Departments, psychiatric hospital, criminal justice system or state supported living centers.

According to *Mental disorder in adults with intellectual disability: prevalence of functional psychiatric illness among a community-based population aged between 16 and 64 years,* published in the Journal of Intellectual and Disability Research in 2001, psychiatric disorders are more prevalent in adults with learning disabilities than in the general population. In addition, a 2000 article in BMJ titled *Mental Health Services for people with intellectual disability: a conceptual framework* notes that appropriate services are often lacking availability, accessibility and adequacy. Individuals with Intellectual & Developmental Disabilities (IDD) have difficulty accessing behavioral health services due to lack of available providers able to deal with the complexity of the dual diagnosis. When a person with IDD has a behaviorally-related incident, care givers usually contact emergency departments or law enforcement. Because admission to a state hospital for a person with an IQ below 70 is virtually impossible and the State Supported Living Centers have no room, these individuals have extended stays in emergency departments, incarceration, or inpatient hospitalization. A crisis center in the community is a more appropriate setting to deal with the behavioral issues and develop a plan to address the behavioral issues on an ongoing basis.

Project Goals
The goal of this project is to develop a crisis response system that will provide temporary emergency respite for the individual and behavioral assessment to determine cause and provide appropriate interventions, such as Cognitive Adaptation Therapy, for the individual to reduce the recurrence of the crisis in the future. By providing a crisis response system patients will be able to receive the appropriate level of service in the most appropriate setting thereby increasing patient outcomes and satisfaction and reducing overall system costs. By DY5, the goal is to serve 100 individuals through the program as a means to deter the individuals from the emergency departments, hospitalization and criminal justice settings.

Challenges or Issues Faced by the Performing Provider
The primary challenge in implementing the crisis center will be identifying staff with Applied Behavioral Analysis training. In an effort to meet this challenge, Hill Country will place the crisis center in Hays County which is located near Texas State University in San Marcos, The University of Texas in Austin, and The University of Texas in San Antonio, all resources for employees with Applied Behavioral Analysis training. In addition, Hill Country will be prepared to offer incentives to recruit the necessary staffing for the crisis center.

How the Project is Related to RHP Goals
Goal 2 - Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Starting Point/Baseline

Baseline Data There is currently no crisis center within the area specializing in individuals with both Intellectual and Developmental Disability and Behavioral health issues**.**

Reason for Selection of Project Options and Components
In reviewing information over the past year, there have been 44 instances identified where consumers would have benefited from a crisis center for individuals dually diagnosed with IDD and mental health but instead entered the Emergency Departments, psychiatric hospital, criminal justice system or state supported living centers. Project options were chosen as a means to provide behavioral interventions in the community setting and to develop a behavioral interventions that will enable the individual to continue to live in the community setting instead of being institutionalized.

Through this project, Hill Country MHDD Centers will develop a crisis center specifically designed to address behavioral crises for individuals with dual diagnosis of IDD and mental health. The goal is to develop a crisis response system that will provide temporary emergency respite for the individual and behavioral assessment to determine cause and provide appropriate interventions, such as Cognitive Adaptation Therapy, for the individual to reduce the recurrence of the crisis in the future. Since individuals with Intellectual and Developmental Disabilities and Psychiatric issues have less ability to adjust between a community setting and an institutional setting, by maintaining the individuals in the community the individual is not traumatized by going to a foreign setting that does not specialize in treating their diagnosis.

In designing a program to address the needs of individuals who have experienced trauma, Hill Country MHDD Centers will:

A) *Assess size, characteristics and needs of individuals with co-occurring IDD and mental health disorders who have crisis episodes* Hill Country will collect and analyze information on individuals who have co-occurring IDD and mental health disorders and have crisis episodes in order to determine appropriate staffing and skill sets necessary for most appropriate service provisions.
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.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals with co-occurring IDD and mental health disorders in order to provide targeted training for staff.
C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Supports Intensity Scale assessment.
D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train staff of the crisis center in the most appropriate interventions to address the behavioral crises of individuals with co-occurring IDD and mental health disorders in order to enable them to safely return to their home with a plan for continued behavioral supports.
E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the ANSA and/or participant surveys, and identify 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.* Hill Country will utilize the Supports Intensity Scale assessment to determine progression of individuals receiving services in the crisis center for individuals with co-occurring IDD and mental health disorder. In addition, Hill Country will do follow up surveys with individuals who receive services and their primary caretakers to determine satisfaction with services and to help ensure stabilization of symptoms

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals beginning service to ensure the project is operational during DY3. DY4 and DY5 have number of new individuals beginning service and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique Community Need Identification Number

Community Need CN.6 Inadequate services throughout the continuum of care for individuals with behavioral health issues such as:
Prevention and supported recovery, screening, outpatient treatment, and integrated care,
intensive outpatient, supported housing, and residential treatment, Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative
There is currently no crisis center within the region specializing in individuals with IDD and mental health disorders.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-10 Quality of Life/Functional Status
IT-10.7 Other Outcome Improvement Target: Supports Intensity Scale

Reasons/Rationale for Selecting the Outcome Measure(s)
The Supports Intensity Scale is a tool designed to measure the intensity of a person with Intellectual and Developmental Disability support needs. It consists of three sections: 1) Support Needs Scale, 2) Supplemental Protection and Advocacy Scale, and 3) Exceptional Medical and Behavioral Support Needs. As a tool, the Supports Intensity Scale is used to measure the frequency and intensity of supports an individual with an intellectual disability needs to meet quality of life goals. Individuals with IDD and mental illness entering the unit should demonstrate improvement during their stay on the overall Supports Intensity Scale (SIS) as improvement is demonstrated on the Exceptional Medical and Behavioral Support Needs. By showing improvement on the SIS, the consumer has shown response to the implemented behavioral supports and is more likely to be successful with a behavioral support plan when returning to their home environment. The Virginia Department of Behavioral Health and Developmental Services has adopted the Supports Intensity Scale as the statewide assessment tool for MR/ID and DS waivers and North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services has prioritized the utilization of the SIS for individuals with high medical and/or behavioral needs..

Relationship to Other RHP Projects

Provision of a Crisis Center for dually diagnosed IDD and mental health disorders as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.2.1 Integrated Care, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services and 1333040307.4 Trauma Informed Care) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3)

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*
From Hill Country MHDD:
133340307.2.1 - Integrated Care
133340307.2.3 - Co-occurring Psychiatric and Substance Use Disorder Services
1333040307.4 - Trauma Informed Care

126844305.2.2 – Bluebonnet Trails Community Centers - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD); for Bastrop, Caldwell, Fayette and Lee Counties

133542405.2.4 - Austin Travis County Integral Care - Community Behavior Support (CBS) Team

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

Relationship to Other Performing Providers' Projects in the RHP

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provides mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Related projects include:

Plan for Learning Collaborative

Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided).

133340307.2.2	***2.13***	***2.13.1*** ***A-E***	*Project Option:* 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting Hays County Mental Health/Intellectual & Developmental Disability Crisis Center
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.2*	*IT 10.7*	*Other Outcome Improvement Target: Supports Intensity Scale*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population Metric 1 P-2.1: Project plans based on evidence/experience and which address the project goals Goal: Submission of project plan Data Source: Project documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $500,000	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health/Intellectual & Developmental Disability Crisis Center) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 15 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $521,685**	**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 3 Estimated Incentive	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 5 Estimated Incentive

		Payment: $ 263,506 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health/Intellectual & Developmental Disability Crisis Center) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 30 individuals beginning service during DY4(for a total of 45) **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $263,506**	Payment: $ 272,764 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health/Intellectual & Developmental Disability Crisis Center) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 55 individuals beginning service during DY5(for a total of 100) **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $272,765**
Year 2 Estimated Milestone Bundle Amount: $500,000	Year 3 Estimated Milestone Bundle Amount: $521,685	Year 4 Estimated Milestone Bundle Amount: $527,012	Year 5 Estimated Milestone Bundle Amount: $545,529
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,094,226			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Co-Occurring Psychiatric and Substance Use Disorder
133340307.2.3 Pass 1

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will implement Co-occurring Psychiatric and Substance Use Disorder Services (COPSD) within Hays County served by Hill Country in RHP 7 in order to meet the needs of individuals with psychiatric and substance use issues within the community setting. Our goal is to reduce emergency department (ED) utilization, inpatient utilization, and incarceration.

Need for the project: Of the 508 individuals receiving mental health services through Hill Country in RHP 7 in November 2012, 78.4% report substance use while 13.9% report substance use at a level that interferes with their daily lives and/or medications. In meeting with area hospitals, they have indicated that individuals with psychiatric disorders who also abuse substances end up in their EDs.

Target population: The target population includes individuals within Hays County who have a psychiatric diagnosis and abuse substances. According to the SAMHSA's National Survey on Drug Use and Health this is 1.84% of the population or 3,300 individuals. Based on the population served in Hill Country's existing behavioral health program in RHP 7, it is anticipated that approximately 30% of our patients within RHP 7 have Medicaid and approximately 75% have income below $15,000 per year. We expect the target population will be similar to this.

Category 1 or 2 expected patient benefits: The project aims to establish COPSD services in a community setting within Hays County served by Hill Country in RHP 7 which will reduce inappropriate ED use and incarceration. The project seeks to provide services to a minimum of 80 individuals from Hays County served by Hill Country in RHP 7 by the end of DY5 (number entering service by DY: DY3 15; DY4 25; and DY5 40).

Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20). Our goal is to have, at a minimum, 20% of the individuals served by the COPSD services showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, inappropriate ED use and incarceration.

Title of Project: Project Option 2.13. Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder

Category / Project Area / Project Option: 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

RHP Project Identification Number: 133340307.2.3 Pass 1

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

Hill Country will identify and train licensed chemical dependency counselors in the provision of co-occurring psychiatric and substance use disorder services such as substance abuse services, cognitive processing therapy, psychosocial rehabilitation and wrap around services to help the individual in their recovery.

According to SAMHSA statistics on co-occurring disorders, 25.7 percent of all adults with serious mental illness also suffer from substance use dependence and 19.7 percent of adults with any mental illness also suffer from substance use dependence. Hill Country currently serves over 1,000 adults with Severe and Persistent Mental Illness on an annual basis within Hays County. Of the individuals served, 78.4% report substance use while 13.9% report substance use at a level that interferes with their daily lives and/or medication. Throughout the 22,000 square mile service delivery area of Hill Country MHDD Centers, there is one individual dedicated to co-occurring service delivery. By expanding this service, Hill Country can better address the need of individuals with co-occurring psychiatric and substance use disorder.

Challenges:
The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

Goals:
The goal of this project is to establish Co-occurring Psychiatric and Substance Use Disorder services throughout Hays County with the ultimate goal of reducing emergency department utilization, inpatient utilization, and incarceration by developing co-occurring psychiatric and substance use disorder services within the community for the co-occurring population. By the end of five years, Hill Country will have established Co-occurring Psychiatric and Substance Use Disorder specialists in Hays County and anticipates providing services to a minimum of 80 consumers within the community over the life of the project.

Relationship to the Regional Goals:

The goal of this project is to establish Co-occurring Psychiatric and Substance Use Disorder services based on each individual's needs within the community setting. By providing these services in the community, Hill Country will be meeting the goal of the Triple Aim by providing patients high-quality and patient-centered care, in the most cost effective way. In addition, the establishment of Co-occurring Psychiatric and Substance Use Disorder services will help achieve the regional goal to expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery (RHP Goal 6).

Starting Point/Baseline

Baseline Data There are currently no COPSD specialty services provided in Hays County.

Rationale

Hill Country will identify and train licensed chemical dependency counselors in the provision of co-occurring psychiatric and substance use disorder services such as substance abuse services, cognitive processing therapy, psychosocial rehabilitation and wrap around services to help the individual

Project Components:
Through the Co-occurring Psychiatric and Substance Use Disorder services, Hill Country MHDD Centers proposes to meet all required project components:

A) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on individuals who have co-occurring psychiatric and substance use disorder and review contributing factors to episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations.
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.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals co-occurring psychiatric and substance use disorder in order to provide targeted training for staff. Primary concentration will be based on SAMSHA's Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices Kit.
C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment.
D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train Co-occurring Psychiatric and Substance Use Disorder specialists in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.
E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment to determine

progression of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services. In addition, Hill Country will do follow up surveys with individuals who receive services to determine satisfaction with services and to help ensure stabilization of symptoms.

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals beginning services to ensure the project is operational during DY3. DY4 and DY5 have number of new individuals beginning service and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique community need identification number the project addresses:
CN.4 Inadequate access to behavioral health care
CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Hill Country MHDD Centers currently has one individual specializing in delivering COPSD services who serves forty individuals on an annual basis. This individual is funded through the Texas Department of State Health Services contract which includes federal and state funds. This project will expand the service to Hays County served by Hill Country in RHP7
.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative
There are currently no specialized services for individuals with Co-occurring Psychiatric and Substance Use Disorder in Hays County.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
This project will enhance the US Dept of Health and Human Services funding Hill Country receives from the Texas Department of State Health Services for provision of COPSD services in Kerr and Gillespie counties by expanding the service to Hays County.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-10 Quality of Life/Functional Status

IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:

Co-occurring Psychiatric and Substance Use Disorder impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to

provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

How Project Supports, Reinforces, Enables Other Projects

Provision of COPSD services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.2.1 Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.4 Trauma Informed Care) by providing specialized services addressing Co-occurring Psychiatric and Substance Use Disorder for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3)

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provide mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap.

201320302.2.1 - Provide ACT Model for Participants of HF PSH: Similar target population, similar intervention, similar diagnosis, same project area

133542405.2.2 - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Mobile Crisis Outreach Team Expansion: Similar target population, same project area

133542405.2.3 - Austin Travis County Integral Care - Hospital and Jail Alternative Project: Crisis Residential Program, Development of behavioral health crisis stabilization services as alternatives to hospitalization

133542405.1.3 - Austin Travis County Integral Care - Introduce, Expand, or Enhance Telemedicine/Telehealth
126844305.1.3 – Bluebonnet Trails Community Centers - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Outpatient Substance Addiction Services for Adult and Youth in Bastrop, Caldwell, Fayette and Lee Counties
137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department
137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation
137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

Project Valuation

Approach for Valuing Project
Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by 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 area avoided). The valuation on this project is based on 80 consumers over the life of the project

133340307.2.3	***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: Co-occurring Psychiatric and Substance Use Disorder
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.3*	*IT 10.2*	*Activities of Daily Living (DLA-20)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population Metric 1 P-2.1: Project plans based on evidence/experience and which address the project goals Baseline: Program is currently not available Goal: Submission of project plan Data Source: Project documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $211,904	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 15 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $221,320**	**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 3 Estimated Incentive Payment: $ 111,674 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder) **Baseline/Goal**: Baseline - 0	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 5Estimated Incentive Payment: $ 111,048 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder)

		individuals served; Goal - 25 individuals beginning service during DY4 (for a total of 40) **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $111,674**	**Baseline/Goal**: Baseline - 0 individuals served; Goal – 40 individuals beginning service during DY5 (for a total of 80) **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $111,048**
Year 2 Estimated Milestone Bundle Amount: $211,904	Year 3 Estimated Milestone Bundle Amount: $221,320	Year 4 Estimated Milestone Bundle Amount: $223,348	Year 5 Estimated Milestone Bundle Amount: $222,096
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $878,668			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Trauma Informed Care

133340307.2.4 Pass 1

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will implement Trauma Informed Care Services within Hays County served by Hill Country in RHP 7 to meet the needs of adults who have experienced trauma that is impacting their behavioral health. The project will incorporate community education on the impact of trauma through Mental Health First Aid training and Trauma Informed Care training, and provide trauma services through interventions such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy to help individuals deal with trauma they have experienced.

Need for the project: Studies have shown that the majority of individuals who are incarcerated have suffered traumatic experiences and that individuals who suffer traumatic experiences are Kaiser's Adverse Childhood Experiences Study shows that individuals are 300% more likely to develop ischemic heart disease. By treating trauma, individuals address the trauma in their life and reduce the chance of internalizing the trauma resulting in physical illnesses, a behavioral health crisis, or in reactions that may result in incarceration or inappropriate emergency department (ED) use.

Target population: The target population is individuals within Hays County who have suffered trauma. This project will target a minimum of 90 individuals who have suffered trauma to the degree that the trauma is impacting their daily life. Based on the population served in Hill Country's behavioral health program in RHP 7, it is anticipated that approximately 30% of our patients in RHP 7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project seeks to provide services to a minimum of 90 individuals from Hays County served by Hill Country in RHP 7 by the end of DY5 (individuals beginning service by DY: DY3 20; DY4 30; and DY5 40).

Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Trauma Informed Care showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, inappropriate ED use and incarceration.

Title of Project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care

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

RHP Project Identification Number: **133340307.2.4 Pass 1**

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Project Description

Overall Project Description

The approach Hill Country will take with this project will include building health communities by offering Mental Health First Aid Training and Trauma Informed Care training to schools, law enforcement, hospitals, physicians, and community organizations. The training will be aimed at helping individuals understand the role trauma plays in everyone's lives and help identify early warning signs of mental health issues. In addition, Hill Country will design programs to offer trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced.

According to Dr. Eric Kandel's *New Intellectual Framework for Psychology*, studies show that medication doesn't change molecular structure of the brain – experiences do. When an individual is exposed to trauma over long periods, it drastically effects their mental health. Further research indicates that many children diagnosed with ADD and ADHD are actually suffering from trauma and PTSD. In the article *Diagnosis: ADHS – or Is It Trauma?,* it is noted that seven of 10 children have been exposed to at least one potentially traumatic event and that preschoolers who had experienced multiple traumatic events were 16 times more likely to have attention problems and 21 times more likely to be overly emotionally reactive including showing symptoms of depression and anxiety than children who had not had such experiences.

Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. In the July-Sept. 2012 Youth Law New, *Trauma-Informed Care Emerging as Proven Treatment for Children, Adults with Behavioral, Mental Health Problems,* states, "Children who are physically or sexually abused, or who go through other trauma-inducing experiences can develop mental health disorders and related problems. Indeed, trauma can fundamentally affect how a young person grows and develops." According to a study cited in *Trauma among Girls in the Juvenile Justice System,* a person traumatized in childhood may resort to criminal behavior. When a survey of all juvenile detainees nationwide was conducted, 93.2% per cent of males and 84% of females reported having had a traumatic experience. In Kaiser's Adverse Childhood Experiences (ACE) study researchers looked at patients with ACE scores of 7 or higher who didn't smoke, didn't drink to excess, and weren't overweight. The study revealed that the risk of ischemic heart disease

(the most common cause of death in the United States) was 360 percent higher than for patients who scored a 0 on the ACE. (Paul Tough, "The Poverty Clinic: Can a Stressful Childhood Make You a Sick Adult?", The New Yorker, March 21, 2011).

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The National Center for Trauma Informed Care, a division of SAMHSA, facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support.

Challenges:

The primary challenge for implementation of the project is recruiting behavioral health staff. Hill Country will address the challenge by offering incentives as necessary.

Goals:

The goal of this project is to establish Trauma Informed Care throughout Hays County served by Hill Country in RHP7. The project will consist of developing Healthy Communities through the use of Mental Health First Aid Training and Trauma Informed Care training as a means to help the community understand the impact of trauma and to help identify symptoms of trauma for earlier treatment. In addition, a system of trauma counseling will be developed including practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced The primary challenge of the project will be recruitment and training of staff for initial implementation. By the end of five years, Hill Country's goal is to have trained at least 80 individuals in Mental Health First Aid and/or Trauma Informed Care and establish Trauma Informed Care throughout Hays County and provided services to at least of 90 consumers within the community over the life of the project.

Relationship to the Regional Goals:

The goal of this project is to provide Trauma Informed Care within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of expanding access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery (RHP 7 Goal #6).

Starting Point/Baseline

Baseline Data Because this is a new initiative, the baseline is 0 patients. A new baseline will be established as part of this project. Hill Country MHDD Centers currently provides Cognitive Behavioral Therapy to individuals suffering from Major Depression and Cognitive Processing Therapy for individuals who have experienced a crisis episode and suffer from Post Traumatic Stress Disorder. During fiscal year 2011, Hill Country MHDD Centers provided 1050 hours of Cognitive Behavioral Therapy and Cognitive Processing Therapy combined. This program would enable Hill Country to acquire and train additional clinicians to provide trauma services, such as Cognitive Behavioral Therapy and Cognitive Processing Therapy, to a broader population at an earlier stage to avoid the exacerbation of symptoms into a crisis episode resulting in utilization of Emergency Departments, potential psychiatric hospitalizations and utilization of the criminal justice system.

Reason for Selection of Project Options and Components

The approach Hill Country will take with this project will include building health communities by offering Mental Health First Aid Training and Trauma Informed Care training to schools, law enforcement, hospitals, physicians, and community organizations. The training will be aimed at helping individuals understand .the role trauma plays in their lives and helping identify early warning signs of mental health issues. In addition, Hill Country will design programs to offer trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced.

Project Components:

Through the implementation of Trauma Informed Care, Hill Country MHDD Centers proposes to meet all required project components:

A) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on individuals who have issues due to an experienced trauma and review contributing factors such as homelessness, noncompliance with medication, diagnosis, unemployment, economic struggles and other factors contributing to trauma in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations for service providers.

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.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals in Trauma Informed Care in order to provide targeted training for staff and to develop innovative wrap around services to help avert future impact of the trauma.

C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the issues leading to the trauma, the services received, the number of individuals receiving follow up services, the number of individuals with recurring symptoms, and progression on the Activities of Daily Living assessment.

D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train Trauma Informed staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of individuals receiving Trauma Informed Care. In addition, Hill Country will do follow up surveys with individuals who receive Trauma Informed Care services to determine satisfaction with services and to help ensure stabilization of symptoms in order to avert additional recurrence of trauma symptoms.

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals beginning service to ensure the project is operational during DY3. DY4 and DY5 have number of new individuals beginning service and continuous evaluation and improvement of the program. These milestones are essential to

evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future

Unique community need identification number the project addresses:

- CN.4 Inadequate access to behavioral health care
- CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

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

Hill Country does not currently have a Trauma Informed Care initiative within Regional Healthcare Partnership 7. The addition of the Trauma Informed Care will enable the commitment of trained staff to provide ongoing trauma services in order to reduce the number psychiatric hospitalizations and avert recurrence of the psychiatric crisis due to triggers related to past trauma.

Related Category 3 Outcome Measure(s)

OD-10 Quality of Life/Functional Status

IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure:

Trauma impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. The DLA-20 is intended to be used by all disabilities and ages.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA-20 will help identify areas the trauma has impacted in their lives such as coping skills, problem solving, family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

How Project Supports, Reinforces, Enables Other Projects

Provision of Mental Health First Aid and Trauma Informed Training coupled with the provision of trauma based services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 13 (133340307.2.1 Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms is reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions.

Relationship to Other Performing Providers' Projects in the RHP

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provide mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap.

Pass 1 Projects also utilizing Project Area 2.13 include the City of Austin – 201320302.2.1, Provide ACT Model for Participants of Housing First Permanent Supportive Housing – and ATCIC, 133542405.2.2, Mobile Crisis Outreach Team Expansion. Both in relation to these and other projects, Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Other related projects included:

133542405.1.1 - Austin Travis County Integral Care - Mental Health First Aid and Suicide Prevention

133542405.2.6 - Austin Travis County Integral Care - Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

Plan for Learning Collaborative

Hill Country MHDD Centers will participate in learning collaboratives to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment.). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by 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 area avoided). The valuation on this project is based on 90 consumers over the life of the project.

133340307.2.4	***2.13***	***2.13.1 A-E***	Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.4*	*IT 10.2*	*Activities of Daily Living*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population Metric 1 P-2.1: Project plans which are based on evidence/experience and which address the project goals Goal: Submission of project plan Data Source: Project Plan documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $268,484	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Trauma Informed Care) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 20 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $279,793**		**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 3 Estimated Incentive Payment: $ 141,512 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 5 Estimated Incentive Payment: $144,770 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year

		(Trauma Informed Care) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 30 individuals beginning service during DY4 (total of 50 individuals) **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $141,513**	(Trauma Informed Care) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 40 individuals beginning service during DY5 (total of 90 individuals) **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $144,770**
Year 2 Estimated Milestone Bundle Amount: $268,484	Year 3 Estimated Milestone Bundle Amount: $279,793	Year 4 Estimated Milestone Bundle Amount: $283,025	Year 5 Estimated Milestone Bundle Amount: $289,540
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,120,842			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Veteran Mental Health Services

133340307.2.5 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will implement Veteran Mental Health Services within Hays County served by Hill Country in RHP7 in order to meet the overall health needs of veterans dealing with behavioral health issues. The project will expand peer support services in an effort to identify veterans and their family members who need comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration and provide community based wrap around behavioral health services for these veterans and their family members in order to treat symptoms prior to the need for utilization of emergency departments, inpatient hospitalization or incarceration.

Need for the project: Hill Country's service area within RHP7 has a veteran population of 11,206 including 284 Reserve Component Service members who were deployed to Operation Enduring Freedom and Operation Iraqi Freedom. In addition, a recent study of death certificates in Texas revealed that the percentage of deaths by suicide for Texas veterans was nearly double the same rate for civilians.

Target population: The target population is veterans within Hays County who have behavioral health issues. The target population consists of the 11,206 veterans including reservists who only receive Veteran Administration benefits for 180 days after federal deployment and their family members in Hays County. Based on the population served in Hill Country's behavioral health program in RHP7, it is estimated that approximately 30% of our behavioral health patients within RHP7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project seeks to provide services to a minimum of ~~90~~ 180 veterans and their family members from Hays County served by Hill Country in RHP7 by the end of DY5 (number beginning service by DY: DY3 40; DY4 60 and DY5 80).

Category 3 outcomes: IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Veteran Mental Health Services showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization.

Title of Project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: **Veterans Mental Health Services**

Project Option 2.13.1

RHP Project Identification Number: **133340307.2.5 Pass 2**

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Project Description

Overall Project Description

As the mental health authority for our service area, Hill Country is well aware of the challenges for Veteran's requiring mental health services. Currently Veteran's within Hays County must travel to San Antonio to receive mental health services. For a majority of these veterans this involves a full day off of work for a one hour appointment.

Hill Country currently has two Veteran Peer Coordinators who recruit volunteer veterans to provide peer support services throughout Hill Country's 19 county, 22,000 square mile service area. Through this project, Hill Country would acquire additional Veteran Peer Coordinators who can actively work to recruit and train veteran peer support providers in a concentrated area. At least one of the additional Veteran Peer Coordinators will be dedicated to serving Hays County. The Veteran Coordinators acquired through this project will create liaisons within the counties, seek out veterans and establish drop-in centers, recruit volunteers, connect veterans with other community resources, create jail outreach and jail diversion for veterans involved with the criminal justice system, coordinate medical and behavioral health referrals as appropriate and serve as a liaison with the local National Guard and Reserve units. This project will also include hiring additional behavioral health clinical staff (Qualified Mental Health Professionals, Licensed Professional Counselors, Nurses and Psychiatrists) for provision of comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration for both Veterans and their families in Blanco and Llano counties, including reservists who only receive Veteran Administration benefits for a few months after active deployment. Wrap around services will be delivered by clinicians who have been trained in cultural competency for the military environment. Wraparound services provided through this project in the local community will complement the Psychiatrist and Counselor services provided by the Veteran Administration at the VA clinics. Between March 2012 and August 2012, Veteran Peer Support services throughout Hill Country's 19 county service area have referred 60 individuals for mental health clinical treatment.

Hill Country MHDD Centers will expand Veteran Mental Health Services throughout Hays County served by Hill Country in RHP7. In establishing the project, Hill Country will review literature and experiences regarding Veteran Mental Health Services to establish appropriate training for staff on the most effective interventions for veteran services. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for veteran peer and community based wrap around behavioral health

services. As a means to determine the success of the interventions, a functional assessment (DLA-20) determining what impact the various stressors have on the individuals daily lives will be completed when a veteran is referred for mental health services and at determined intervals during treatment. In order to track individuals receiving treatment in the program, Hill Country will establish specific units and subunits within its information technology system (Anasazi) that will enable reporting on Veteran Peer and Mental Health services delivered within the program as well as by location within the program.

Challenges or Issues Faced by the Performing Provider/How the Project Addresses those Challenges

The primary challenge for implementation of the project is recruiting qualified and dedicated staff. Hill Country will address the challenge by offering incentives as necessary. An additional challenge is creating an environment where veterans feel safe and comfortable in revealing issues they are encountering. Hill Country will overcome this challenge by providing military cultural competency to clinicians and by assuring veterans that all information is held in strictest confidence.

Project Goals:

The goal of this project is to expand Veteran Peer and Mental Health services throughout Hays County served by Hill Country in RHP7 in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population. By the end of the project, Hill Country anticipates that 180 additional veterans and their family members will be referred from Veteran Peer Services to receive community based wrap around behavioral health services through the Veteran Mental Health Services project.

Relationship to the Regional Goals:

The goal of this project is to establish Veteran Mental Health Services based on each individual's needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal of:

(3) Improve the patient experience of care by investing in patient centered, integrated, comprehensive care that is coordinated across systems, and

(6) Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data

Hill Country MHDD Centers currently has two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the service to add a concentrated Veteran Peer Coordinator to serve Hays County served by Hill Country in RHP7 in order to recruit and train veteran peer service providers and provide identified mental health services as needed. In addition, the project will recruit additional behavioral health professionals to provide community based wrap around services to address the behavioral health needs of veterans and their family members. The DLA20 assessment will be performed on each individual referred from wrap around behavioral health services as their baseline and the percentage of individuals who have improved DLA20 scores on a subsequent assessment after treatment will be utilized to show improvement.

Rationale

According to 2012 population estimates from the Texas Department of State Health Services Population Data System for Texas Population Estimates Program and statistics from the Veteran's Administration 9/30/08 Projection of Veteran's by 110th Congressional District, Vet Pop 2012, Hays County served by Hill Country within RHP7 has a total population of 179,519 with a Veteran population of 11,206, or 6.2% of the total population. Additionally, 284 Reserve Component Service members from Hays County were deployed to Operation Enduring Freedom and Operation Iraqi Freedom.

Studies conducted by the Veterans Administration state that nearly 20% of the suicides that occur in the U.S. are committed by veterans. According to a study of death certificates completed by the Austin American Statesman, the percentage of deaths of Texas veterans caused by suicide from 2003 through 2011 was 21.5% compared to 12.4% for the overall Texas population. Of Texas Veterans with a primary diagnosis of post-traumatic stress disorder who died during this period, 80% died of overdose, suicide or a single-vehicle crash. During discussions Hill Country held with County Veteran Service Officers within the region, it was noted that there is a need for Mental Health services for Veterans due to the transportation and time commitment needed to access Veteran Administration services as well as the reluctance of veterans to acknowledge a potential mental health issue with the Veterans Administration.

Hill Country will identify and train Veteran Peer Coordinators in the provision of veteran peer support services including identifying and seeking out veterans needing services, recruit veteran peer support providers, creating drop-in centers for veterans, identify and connecting with current resources, and incorporating jail diversion as appropriate for veterans in touch with the criminal justice system.

Project Components

Through the Veteran Mental Health services project, Hill Country MHDD Centers proposes to meet all required project components:

F) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on veterans with mental health issues and review contributing factors to episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations.

G) *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.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving veteran mental health issues in order to provide targeted training for staff. One such resource is the Citizen Soldier Support Program provided by the South East Area Health Education Center.

H) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment (DLA-20).

I) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train staff in the most

appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

J) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of Veterans referred for Veteran Mental Health services. In addition, Hill Country will do follow up surveys with individuals who receive Veteran Peer Services to determine satisfaction with services and to help ensure stabilization of symptoms.

Reason for Selection of Milestones and Metrics

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals served to ensure the project is operational during DY3. DY4 and DY5 have improved functional status of individuals served and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique community need identification number the project addresses:

- CN.4 Inadequate access to behavioral health care
- CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

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

Hill Country MHDD Centers currently has two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the service to add a concentrated Veteran Peer Coordinator to serve Hays County served by Hill Country within RHP7 in order to recruit and train veteran peer service providers and recruiting additional behavioral health clinical personnel to provide identified mental health services to veterans as needed.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-10 Quality of Life/Functional Status; IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure

Behavioral health issues impact veteran's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

How Project Supports, Reinforces, Enables Other Projects

Provision of Veteran Mental Health Services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services and 1333040307.4 Trauma Informed Care, 133340307.2.6 Children's Mental Health Crisis Respite Center, 133340307.2.7 Children's Mental Health Trauma Services, 13340307.2.8 Mental Health Court, 133340307.2.9 Whole Health Peer Support, 133340307.2.10 Adolescent Whole Health Peer Support, 133340307.2.11 Family Partner and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provide mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

133542405.2.1 - Austin Travis County Integral Care - Integrate Primary and Behavioral Health Care Services

133542405.2.6 - Austin Travis County Integral Care - Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation

137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.;http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

The valuation on this project is based on an estimated 180 individuals receiving veteran mental health services over the life of the project.

133340307.2.5	***2.13.1***	***2.13.1 A-E***	Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health Services	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.6*	*IT 10.2*	*Activities of Daily Living (DLA-20)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population (Veteran Mental Health) Metric 1 P-2.1: Project plans which are based on evidence/experience and which address the project goals Baseline: No formal plan has been designed to track veterans from peer support to receipt of clinical behavioral health services Goal: Submission of project plan Data Source: Project documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $713,366	**Milestone 2** [I-X]: Number of targeted individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning service during demonstration year (Veteran Mental Health) **Baseline/Goal**: Baseline - 0 ; Goal – 40 individuals beginning services in DY3. **Data Source:** Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $734,685**		**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 43 Estimated Incentive Payment: $ 370,567 **Milestone 4** [I-X]: Number of targeted individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 45 Estimated Incentive Payment: $ 379,359 **Milestone 6** [I-X]: Number of targeted individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning

		service during demonstration year (Veteran Mental Health) **Baseline/Goal**: Baseline - 0 ; Goal – 60 individuals beginning services in DY4 (100 individuals total). **Data Source:** Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $370,567**	service during demonstration year (Veteran Mental Health) **Baseline/Goal**: Baseline - 0 ; Goal – 80 individuals beginning services in DY5 (180 individuals total). **Data Source:** Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $379,358**
Year 2 Estimated Milestone Bundle Amount: $713,366	Year 3 Estimated Milestone Bundle Amount: $734,685	Year 4 Estimated Milestone Bundle Amount: $741,134	Year 5 Estimated Milestone Bundle Amount: $758,717
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,947,902			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Children's Mental Health Crisis Center

133340307.2.6 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012.

Intervention(s): This project will implement Children's Mental Health Crisis Respite Center within Hays County served by Hill Country in RHP 7 to meet the needs of children in a behavioral health crisis in order to avoid psychiatric hospitalization. The crisis center will be set up similar to a group home environment with more intensive staff to consumer ratios and with staff that have additional training in children's mental health. The crisis center will serve Hays County in RHP7 as well as the other 18 counties in Hill Country's service area (Bandera, Blanco, Comal, Edwards, Gillespie, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde).

Need for the project: From September 1, 2011 through August 31, 2012, Hill Country's service area had 134 children who were admitted to either a state or private psychiatric hospital. Hill Country also screened 190 children during the same time period who were experiencing a crisis episode. Both of these populations could have benefitted from a Children's Mental Health Crisis Respite Center but no such center is currently available in Hill Country's 19 county service area.

Target population: The target population is children in behavioral health crisis Hays County in RHP7 as well as the other 18 counties in Hill Country's service area (Bandera, Blanco, Comal, Edwards, Gillespie, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde), approximately 190 children per year. This project will target a minimum of 200 children in behavioral health crisis by the end of DY5 (children beginning service by DY: DY3 30; DY4 70; and DY5 100). Based on the population served in Hill Country's behavioral health program in RHP 7, it is anticipated that approximately 30% of our patients in RHP 7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project seeks to provide services to a minimum of 190 individuals from Hays County served by Hill Country in RHP 7 by the end of DY5.

Category 3 outcomes: OD-10: Quality of Life/Functional Status, IT-10.7 Other Outcome Improvement Target Traumatic Events Screening Inventory
Our goal is to have, at a minimum, 20% of the individuals served by the Children's Trauma Informed Care showing improvement on the Traumatic Events Screening Inventory which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, inappropriate ED use and incarceration.

Title of Project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting - Children's Mental Health Crisis Center

Category / Project Area / Project Option: 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

RHP Project Identification Number: 133340307.2.6 Pass 2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

Hill Country plans to develop a crisis response center for children with mental health issues that will provide temporary emergency respite for the child in order to reduce psychiatric hospital utilization. From September 1, 2011 through August 31, 2012, Hill Country's service area had 134 children who were admitted to either a state or private psychiatric hospital. Hill Country also screened 190 children during the same time period who were experiencing a crisis episode. Both of these populations could have benefitted from a Children's Mental Health Crisis Respite Center but no such center is currently available in Hill Country's 19 county service area.

It is anticipated that the Children's Mental Health Crisis Respite Center will be set up similar to a group home environment with more intensive staff to consumer ratios and with staff that have additional training in children's mental health. By maintaining the individuals in the community the individual is not traumatized by going to a foreign setting that does not specialize in treating their diagnosis. The crisis center will serve Hays County in RHP7 as well as the other 18 counties in Hill Country's service area (Bandera, Blanco, Comal, Edwards, Gillespie, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde).

Project Goals The philosophy of the Children's Mental Health Crisis Respite Center will be to maintain those at risk for psychiatric hospitalization in the community by organizing more appropriate resources. The goal is to intervene in crisis situations and access a crisis respite bed in an effort towards crisis stabilization. The program's will be designed to achieve the following goals: avoid hospitalization or other overly restrictive placement by providing short-term residential alternatives; provide structure and support for children and adolescents to facilitate symptom stabilization; provide respite for other family members; provide crisis assessment, individual planning and family needs assessment; develop crisis solution plans and longer-term treatment plans by determining family strengths and community resources; provide linkages to appropriate community mental health resources; and facilitate a smooth transition back to home. By DY5, the goal is to serve 100 individuals through the program as a means to deter the individuals from the emergency departments, hospitalization and criminal justice settings.

Challenges or Issues Faced by the Performing Provider

The primary challenge in implementing the children's mental health crisis center will be identifying staff with appropriate dedication and training. In an effort to meet this challenge, Hill Country will place the crisis center in Hays County which is located near Texas State University in San Marcos, The University of

Texas in Austin, and The University of Texas in San Antonio, all resources for employees with specialized health care training and education. In addition, Hill Country will be prepared to offer incentives to recruit the necessary staffing for the children's mental health crisis center.

How the Project is Related to RHP Goals

Regional Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

By offering a children's mental health crisis center, children are able to stay in the local community instead of being institutionalized in a psychiatric hospital.

Starting Point/Baseline

Baseline Data There is currently no children's mental health crisis center within Hill Country's 19 county service area**.**

Reason for Selection of Project Options and Components

From September 1, 2011 through August 31, 2012, Hill Country's service area had 134 children who were admitted to either a state or private psychiatric hospital. Hill Country also screened 190 children during the same time period who were experiencing a crisis episode. Both of these populations could have benefitted from a Children's Mental Health Crisis Respite Center but no such center is currently available in Hill Country's 19 county service area.

Project options were chosen as a means to provide children's mental health crisis respite services in the community setting and to develop interventions that will enable the child to continue to live in the community setting instead of being institutionalized.

Through this project, Hill Country MHDD Centers will develop a children's mental health crisis center specifically designed to address children with a mental health crisis who otherwise would require hospitalization. The goal is to develop a children's mental health crisis center that will provide temporary emergency respite for the child and behavioral assessment to determine cause and provide appropriate interventions for the individual and family in order to reduce the recurrence of the crisis in the future. The program will be designed to simulate a group home environment and to maintain the child in the community to reduce the impact of trauma by avoiding psychiatric hospitalization.

In designing a program to address the needs of individuals who have experienced trauma, Hill Country MHDD Centers will:

A) *Assess size, characteristics and needs of individuals with co-occurring IDD and mental health disorders who have crisis episodes* Hill Country will collect and analyze information on children who would benefit from crisis respite services in order to determine appropriate staffing and skill sets necessary for most appropriate service provisions.
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.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving children who would benefit from crisis respite services in order to provide targeted training for staff.

C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Traumatic Events Screening Inventory.

D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train staff of the crisis center in the most appropriate interventions to address the children's mental health crises in order to enable them to safely return to their home with a plan for continued services and supports.

E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the ANSA and/or participant surveys, and identify 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.* Hill Country will utilize the Supports Intensity Scale assessment to determine progression of individuals receiving services in the children's mental health crisis center. In addition, Hill Country will do follow up surveys with individuals who receive services and their primary caretakers to determine satisfaction with services and to help ensure stabilization of symptoms

Reason for Selection of Milestones and Metrics

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals beginning service to ensure the project is operational during DY3. DY4 and DY5 have new individuals beginning service and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique Community Need Identification Number

CN.6: Inadequate services throughout the continuum of care for individuals with behavioral health issues such as: Prevention and supported recovery, screening, outpatient treatment, and integrated care, intensive outpatient, supported housing, and residential treatment, Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care.

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

There are currently no children's mental health crisis center services available within Hill Country's 19 county service area.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-10 Quality of Life/Functional Status
IT-10.7 Other Outcome Improvement Target: Traumatic Events Screening Inventory

Reasons/Rationale for Selecting the Outcome Measure(s)

The Traumatic Events Screening Inventory for Children (TESI-C) protocol is a guide for clinical and/or research interviewing to screen for a child's history of exposure to potentially traumatic experiences. The protocol is designed to help clinicians focus in a systematic fashion on the primary domains of trauma for children, which include direct exposure to or witnessing of severe accidents, illness or disaster, family or community conflict or violence, and sexual molestation. The questions are arranged to hierarchically review experiences in an order that helps the child tolerate the possible stress of disclosing traumatic experiences: gradually increasing the intimacy of the experiences (i.e., sexual trauma is reserved for the end of the interview) and so to help the child recall not only physical harm/violence but also incidents of threatened harm and witnessed trauma. The screening includes 16 items that survey the domains of potential traumatic experiences. Each item rated yes is followed immediately with probes to determine the child and interviewer's view of the life threat/severe injury/risk of severe injury involved and three probes eliciting the child's appraisal of the potentially traumatic incident described for that item.

The TESI-C is being utilized in this project to determine trauma that impacts a child's mental health status as the trauma must be addressed before the child and family can deal with the mental health issues. According to *How to Manage Trauma,* trauma is a risk factor in nearly all behavioral health and substance use disorders and more than 33% of youths exposed to community violence will experience Post Traumatic Stress Disorder, a very severe reaction to traumatic events.

How Project Supports, Reinforces, Enables Other Projects

Provision of Children's Mental Health Crisis Center services for children with mental health disorders as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, 133340307.4 Trauma Informed Care, 133340307.2.5 Veteran's Mental Health, 133340307.2.7 Children's Mental Health Trauma Services, 13340307.2.8 Mental Health Court, 133340307.2.9 Whole Health Peer Support, 133340307.2.10 Adolescent Whole Health Peer Support, 133340307.2.11 Family Partner and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms is reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

Relationship to Other Performing Providers' Projects in the RHP

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7. The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provides mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

133542405.2.3 - Austin Travis County Integral Care - Hospital and Jail Alternative Project: Crisis Residential Program, Development of behavioral health crisis stabilization services as alternatives to hospitalization
137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department
126844305.2.3 – Bluebonnet Trails Community Centers - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population, criminal justice systems: Services for Justice-Involved Youth and Adults: Bastrop, Caldwell, Fayette and Lee Counties
IL - 126844305.1.2 - Bluebonnet Trails Community Services - Child Crisis Respite through Therapeutic Foster Care
T - 137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

Plan for Learning Collaborative

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 200 individuals receiving children's mental health crisis center services over the life of the project.

133340307.2.6	***2.13.1***	***2.13.1A-E***	*Project Option:* 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*IT-10.7*	*133340307.3.7*	*Other Outcome Improvement Target: Traumatic Events Screening Inventory (TESI-C)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population Metric 1 P-2.1: Project plans based on evidence/experience and which address the project goals Baseline: No intervention has been designed Goal: Submission of project plan Data Source: Project documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $784,701	**Milestone 2** P-3: Serve individuals with targeted complex needs Metric 1 P-3.1: Number of targeted individuals served in the project Baseline: 0 individuals served Goal: 15 during FFY14 Data Source: Hill Country MHDD records/EHR/Project documentation Milestone 2 Estimated Incentive Payment: $808,153 **Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Children's Mental Health Crisis		**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records, project reports Milestone 4 Estimated Incentive Payment: $ 407,624 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records, project reports Milestone 4 Estimated Incentive Payment: $ 417,294 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of

	Center) **Baseline/Goal**: Baseline - 0 individuals served; Goal -30 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $808,153**	targeted individuals beginning services during demonstration year (Children's Mental Health Crisis Center) **Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 70 new individuals beginning services during DY4 (for a total of 100); **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $407,623**	targeted individuals beginning services during demonstration year (Children's Mental Health Crisis Center) **Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 100 new individuals beginning services during DY5 (for a total of 200); **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $417,294**
Year 2 Estimated Milestone Bundle Amount: $784,701	Year 3 Estimated Milestone Bundle Amount: $808,153	Year 4 Estimated Milestone Bundle Amount: $815,247	Year 5 Estimated Milestone Bundle Amount: $834,588
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,242,689			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Children's Trauma Informed Care

133340307.2.7 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will implement Children's Trauma Informed Care Services within Hays County served by Hill Country in RHP 7 to meet the needs of children who have experienced trauma that is impacting their behavioral health. The project will design programs to offer trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy aimed specifically at children in order to help children deal with trauma they have experienced.

Need for the project: Research indicates that many children diagnosed with ADD and ADHD are actually suffering from trauma and PTSD. Hill Country has found this to hold true with the children brought in for services. In the article *Diagnosis: ADHD – or Is It Trauma?,* it is noted that seven of 10 children have been exposed to at least one potentially traumatic event and that preschoolers who had experienced multiple traumatic events were 16 times more likely to have attention problems and 21 times more likely to be overly emotionally reactive including showing symptoms of depression and anxiety than children who had not had such experiences. (http://healthyliving.msn.com/diseases /adhd/diagnosis-adhd%E2%80%94or-is-it-trauma-1) By treating trauma, individuals address the trauma in their life and reduce the chance of internalizing the trauma resulting in physical illnesses, a behavioral health crisis, or in reactions that may result in incarceration or inappropriate emergency department (ED) use.

Target population: The target population is individuals within Hays County who have suffered trauma. This project will target a minimum of 60 children who have suffered trauma to the degree that the trauma is impacting their daily life. Based on the population served in Hill Country's behavioral health program in RHP 7, it is anticipated that approximately 30% of our patients in RHP 7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project seeks to provide services to a minimum of ~~60~~ 160 individuals from Hays County served by Hill Country in RHP 7 by the end of DY5 (children entering service by DY: DY3 30; DY4 50; and DY5 80).

Category 3 outcomes: IT-10.7 Other Outcome Improvement Target Traumatic Events Screening Inventory. Our goal is to have, at a minimum, 20% of the individuals served by the Children's Trauma Informed Care showing improvement on the Traumatic Events Screening Inventory which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization, inappropriate ED use and incarceration.

Title of Project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Children's Trauma Informed Care
Category / Project Area / Project Option: 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

RHP Project Identification Number: 133340307.2.7 Pass 2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The National Center for Trauma Informed Care, a division of SAMHSA, facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support.

The approach Hill Country will take with this project will be to design programs to offer trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy aimed specifically at children in order to help children deal with trauma they have experienced. Trauma occurs when a child is overwhelmed by events or circumstances and responds with intense fear, horror, and helplessness. Extreme stress overwhelms the child's capacity to cope. Trauma for a child can stem from abuse or neglect; physical, emotional or sexual abuse; grief and loss; accidents and natural disasters; witnessing acts of violence. These are experiences which many children encounter.

Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. In the July-Sept. 2012 Youth Law New, *Trauma-Informed Care Emerging as Proven Treatment for Children, Adults with Behavioral, Mental Health Problems,* states, "Children who are physically or sexually abused, or who go through other trauma-inducing experiences can develop mental health disorders and related problems. Indeed, trauma can fundamentally affect how a young person grows and develops." According to a study cited in *Trauma among Girls in the Juvenile Justice System,* a person traumatized in childhood may resort to criminal behavior. When a survey of all juvenile detainees nationwide was conducted, 93.2% per cent of males and 84% of females reported having had a traumatic experience. In Kaiser's Adverse Childhood Experiences (ACE) study researchers looked at patients with ACE scores of 7 or higher who didn't smoke,

didn't drink to excess, and weren't overweight. The study revealed that the risk of ischemic heart disease (the most common cause of death in the United States) was 360 percent higher than for patients who scored a 0 on the ACE. (Paul Tough, "The Poverty Clinic: Can a Stressful Childhood Make You a Sick Adult?", The New Yorker, March 21, 2011).

Challenges or Issues Faced by the Performing Provider

The primary challenge for implementation of the project is recruiting behavioral health staff, especially a Child Psychiatrist with specific focus on trauma informed care. Commitment to understanding how trauma impacts the overall health of a child and integrating that knowledge into everyday practice will be the key in educating identified staff for the project to be successful. Hill Country will address the challenge by offering incentives as necessary and offering specific training regarding the impact of trauma on children.

Project Goals

The goal of this project is to establish Child Focused Trauma Informed Care throughout Hays County served by Hill Country in RHP7. A system of trauma counseling will be developed including practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help children deal with trauma they have experienced The primary challenge of the project will be recruitment and training of staff for initial implementation, especially a Child Psychiatrist with specific emphasis on trauma informed care. By the end of five years, Hill Country's goal is to establish Child Focused Trauma Informed Care and to provide services to at least 160 children within the community over the life of the project with a minimum of 20% of the children served showing improvement based on the Traumatic Events Screening Inventory.

Relationship to the Regional Goals

The goal of this project is to provide Child Focused Trauma Informed Care within the community setting. By providing these services in the community, Hill Country will be meeting the regional goal 6 of expanding access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data

Because this is a new initiative, the baseline is 0 patients. A new baseline will be established as part of this project. This program would enable Hill Country to acquire and train clinicians to provide child trauma services, such as Cognitive Behavioral Therapy and Cognitive Processing Therapy, to a broad child population at an early stage to avoid the exacerbation of symptoms into a crisis episode resulting in utilization of Emergency Departments, potential psychiatric hospitalizations and utilization of the criminal justice system.

Reason for Selection of Project Options and Components

According to Dr. Eric Kandel's New Intellectual Framework for Psychology, studies show that medication doesn't change molecular structure of the brain – experiences do. When an individual is exposed to trauma over long periods, it drastically affects their mental health and further research indicates that many children diagnosed with ADD and ADHD are actually suffering from trauma and PTSD. Hill Country has found this to hold true with the children brought in for services. In the article *Diagnosis: ADHS – or Is It Trauma?,* it is noted that seven of 10 children have been exposed to at least one potentially traumatic event and that preschoolers who had experienced multiple traumatic events were 16 times more likely to have attention problems and 21 times more likely to be overly emotionally reactive including showing symptoms of depression and anxiety than children who had not had such experiences.

According to the National Council publication, *How to Manage Trauma,* there is a direct correlation between trauma and physical health conditions such as diabetes, COPD, heart disease, cancer and high blood pressure. In addition, nearly all children who witness a parental homicide or sexual assault will develop Post Traumatic Stress Disorder. Similarly, 90% of sexually abuse children, 77% of children exposed to a school shooting, and 35% of youth exposes to community violence develop Post Traumatic Stress Disorder.

The approach Hill Country will take with this project will be designing programs to offer child focused trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help children deal with trauma they have experienced.

Project Components:

Through the implementation of Child Trauma Informed Care, Hill Country MHDD Centers proposes to meet all required project components:

A) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on children who have issues due to an experienced trauma and review contributing factors such as homelessness, noncompliance with medication, diagnosis, unemployment, economic struggles and other factors contributing to trauma in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations for service providers.
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.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving children in Trauma Informed Care in order to provide targeted training for staff and to develop innovative wrap around services to help avert future impact of the trauma.
C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the issues leading to the trauma, the services received, the number of individuals receiving follow up services, the number of individuals with recurring symptoms, and progression on the Activities of Daily Living assessment.

D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train Child Focused Trauma Informed staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Traumatic Events Screening Inventory (TESI-C) to determine progression of individuals receiving Children's Trauma Informed Care. In addition, Hill Country will do follow up surveys with individuals who receive Children's Trauma Informed Care services to determine satisfaction with services and to help ensure stabilization of symptoms in order to avert additional recurrence of trauma symptoms.

Reason for Selection of Milestones and Metrics

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are essential during DY2. The DY3 milestone concentrates on number of individuals beginning service to ensure the project is operational during DY3. DY4 and DY5 have new individuals beginning service and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future

Unique community need identification number the project addresses:

CN.4 Inadequate access to behavioral health care
CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

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

Hill Country does not currently have a Children's Trauma Informed Care initiative within Regional Healthcare Partnership 7. The addition of Children's Trauma Informed Care will enable the commitment of trained staff to provide ongoing trauma services in order to reduce the number psychiatric hospitalizations and avert recurrence of the psychiatric crisis due to triggers related to past trauma.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-10 Quality of Life/Functional Status
IT-10.7 Other Outcome Improvement Target: Traumatic Events Screening Inventory

Reasons/Rationale for Selecting the Outcome Measure(s)
The Traumatic Events Screening Inventory for Children (TESI-C) protocol is a guide for clinical and/or research interviewing to screen for a child's history of exposure to potentially traumatic experiences. The protocol is designed to help clinicians focus in a systematic fashion on the primary domains of trauma for children, which include direct exposure to or witnessing of severe accidents, illness or disaster, family or community conflict or violence, and sexual molestation. The questions are arranged to hierarchically review experiences in an order that helps the child tolerate the possible stress of disclosing traumatic experiences: gradually increasing the intimacy of the experiences (i.e., sexual trauma is reserved for the end of the interview) and so to help the child recall not only physical harm/violence but also incidents of threatened harm and witnessed trauma. The screening includes 16 items that survey the domains of potential traumatic experiences. Each item rated yes is followed immediately with probes to determine the child and interviewer's view of the life threat/severe injury/risk of severe injury involved and three probes eliciting the child's appraisal of the potentially traumatic incident described for that item.

The TESI-C is being utilized in this project to determine trauma that impacts a child's mental health status as the trauma must be addressed before the child and family can deal with the mental health issues. According to *How to Manage Trauma,* trauma is a risk factor in nearly all behavioral health and substance use disorders and more than 33% of youths exposed to community violence will experience Post Traumatic Stress Disorder, a very severe reaction to traumatic events.

How Project Supports, Reinforces, Enables Other Projects
Provision of Child Trauma Informed Care services for children with mental health disorders as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, 133340307.4 Trauma Informed Care, 133340307.2.5 Veteran's Mental Health, 133340307.2.6 Child Mental Health Crisis Center, 13340307.2.8 Mental Health Court, 133340307.2.9 Whole Health Peer Support, 133340307.2.10 Adolescent Whole Health Peer Support, 133340307.2.11 Family Partner and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms is reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

Relationship to Other Performing Providers' Projects in the RHP
Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7. The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provides mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning

collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

133542405.1.1 - Austin Travis County Integral Care - Mental Health First Aid and Suicide Prevention

133542405.2.6 - Austin Travis County Integral Care - Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

Plan for Learning Collaborative

Hill Country MHDD Centers will participate in a learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

The valuation on this project is based on an estimated 60 individuals receiving children's trauma informed care services over the life of the project.

133340307.2.7	***2.13***	***2.13.1 A-E***	Project Option 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.8*	*IT 10.7*	*Traumatic Events Screening Inventory*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population Metric 1 P-2.1: Project plans which are based on evidence/experience and which address the project goals Goal: Submission of project plan Data Source: Project Plan documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $570,691	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Children's Trauma Informed Care) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 30 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $587,747**	**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records, project reports Milestone 3 Estimated Incentive Payment: $ 296,454 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Children's Trauma Informed Care)	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records, project reports Milestone 5 Estimated Incentive Payment: $303,487 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Children's Trauma Informed Care)

		Baseline/Goal: Baseline - 0 individuals beginning service in DY2; Goal – 50 new individuals beginning services during DY4 (for a total of 80); **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $296,453**	**Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 80 new individuals beginning services during DY5 (for a total of 160); **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $303,486**
Year 2 Estimated Milestone Bundle Amount: $570,691	Year 3 Estimated Milestone Bundle Amount: $587,747	Year 4 Estimated Milestone Bundle Amount: $592,907	Year 5 Estimated Milestone Bundle Amount: $606,973
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,358,318			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Mental Health Court

133340307.2.8 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012.

Intervention(s): This project will implement a Mental Health Court within Hays County to meet the overall health needs of individuals dealing with behavioral health issues who frequently utilize the emergency departments or criminal justice system. The project will have dedicated case workers to provide wraparound services for the identified individuals and will have dedicated courts to monitor the patient's treatment compliance.

Need for the project: Hays County has approached Hill Country regarding establishing a Mental Health Court in order to increase treatment compliance of individuals with mental illness identified as having frequent utilization of emergency departments, the criminal justice system, and/or psychiatric inpatient services in an effort to deter inappropriate utilization of these services. The county has targeted this approach as one way to address the overcrowding at the Hays County jail.

Target population: The target population is individuals with mental illness from within Hays County who are frequently utilize the emergency departments, criminal justice system, and/or psychiatric inpatient services. The project is aimed at serving a minimum of 125 individuals from the target population. Based on the population served in Hill Country's behavioral health program in RHP7, approximately 30% of our behavioral health patients within RHP7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project aims to establish a Mental Health Court to serve Hays County within RHP7. The Mental Health Court will monitor patient compliance with treatment protocol and provide wraparound behavioral health services to individuals in the program. The project seeks to provide services to a minimum of 125 individuals in RHP7 by the end of DY5 (number beginning service by DY: DY3 25; DY4 40; DY5 60).

Category 3 outcomes IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Mental Health Court Services showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization.

Title of Project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting - Mental Health Courts

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

RHP Project Identification Number: 133340307.2.8 Pass 2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: **133340307**

Project Description

Overall Project Description

A Mental health court is a judicial program that provides a specialized docket for defendants with mental illnesses. Mental health courts make decisions about the state of mind of people charged with criminal offences. Such courts give the defendants an opportunity to participate in court-supervised treatment. A mental health court consists of a judge, court personnel, and treatment providers. They provide continued mental health status assessments with individualized sanctions and incentives. They also make efforts to resolve a case upon successful completion of mandated treatment as a means to avoid unnecessary incarceration or hospitalization. They plan and participate in ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities.

Hays County has approached Hill Country MHDD Centers regarding establishing Mental Health Courts in order to increase treatment compliance of individuals with mental illness who are identified as having frequent utilization of Emergency Departments, the criminal justice system, and/or psychiatric inpatient services. The county has targeted this approach as one way to address the overcrowding at the Hays County jail. Hill Country MHDD Centers would hire Community Health Workers to serve as Case Managers to deliver necessary community-based interventions according to the individuals need. Community-based interventions may include psychosocial rehabilitation, Cognitive Behavioral Therapy, Cognitive Processing Therapy, supported employment, transportation, peer support, and other services in accordance with the individual's needs. The identified consumers served through this project would appear regularly before the Mental Health court to increase the accountability of the individual to the necessary treatment in order to reduce utilization of the Emergency Department, the Criminal Justice system, or Psychiatric Inpatient settings

The mental health court in Pittsburgh, which has been operating since 2001, determined that only 10% of individuals who completed the court were rearrested compared to a 68% national average for all defendants. According to the Bureau of Justice Assistance "when it comes to mentally ill offenders, mental health courts have shown positive outcomes related to treatment and satisfaction with the process. A common perception is that the informality and decreased adversarial nature of the mental health court, when compared to traditional courts, decreases the barriers mentally ill offenders often face in receiving treatment through traditional courts. Mental health courts have been shown to provide more treatment, better treatment and faster linkages to appropriate treatment."

In other studies, a 2003 study of the Broward County (Fla.) mental health court determined that the program increased defendants' access to treatment services and that mental health court participants were more likely that non-participants to continue treatment after the program concluded. Another 2003 study of the Clark County (Wash.) mental health court, concluded participants had significantly more case management, outpatient service days, and medication monitoring after enrollment than before enrollment. Additionally, participants had fewer crisis intervention and inpatient treatment days post-enrollment.

In designing the Mental Health Courts, Hill Country will work with the courts to review other successful mental health courts, identify the target population to be served, have dedicated case managers for the courts, develop necessary legal agreements for court participation, create linkages for services beyond mental health services, and work with the courts in establishing ongoing procedures.

Challenges or Issues Faced by the Performing Provider
The primary challenge for implementation of the project is recruiting qualified and dedicated staff. Hill Country will address the challenge by offering incentives as necessary.

Project Goals
The goal of this project is to develop Mental Health Courts in Hays County in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population and to have a minimum of 125 individuals served through the mental health courts by the end of DY5.

Relationship to the Regional Goals
The goal of this project is to establish Mental Health Court services in Hays County based on each individual's needs within the community setting. By providing these services in the community, Hill Country will meet the following regional goals:

#3: Improve the patient experience of care by investing in patient centered, integrated, comprehensive care that is coordinated across systems, and

#6: Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data
Hill Country MHDD Centers does not currently have a mental health court within its service area. This will be a new program for the area.

Rationale
Reason for Selection of Project Options and Components
Based on the current Texas Recommended Authorization Guidelines, 11% of the individuals receiving mental health services from Hill Country have been arrested for at least a misdemeanor in the last 90 days and 7% have been arrested for at least 3 or more misdemeanors in the last 180 days. In an effort to increase compliance with behavioral health treatment in order to deter future involvement with the criminal justice system, this project proposes the implementation of mental health courts.

Hays County has approached Hill Country MHDD Centers regarding establishing Mental Health Courts in order to increase treatment compliance of individuals with mental illness who are identified as having

frequent utilization of Emergency Departments, the criminal justice system, and/or psychiatric inpatient services. Hill Country MHDD Centers would hire Community Health Workers to serve as Case Managers to deliver necessary community-based interventions according to the individuals need. Community-based interventions may include psychosocial rehabilitation, Cognitive Behavioral Therapy, Cognitive Processing Therapy, supported employment, transportation, peer support, and other services in accordance with the individual's needs. The identified consumers served through this project would appear regularly before the Mental Health court to increase the accountability of the individual to the necessary treatment in order to reduce utilization of the Emergency Department, the Criminal Justice system, or Psychiatric Inpatient settings

In designing a program to address the needs of individuals with mental illness identified with frequent utilization of the Emergency Department, the Criminal Justice system or Psychiatric Inpatient settings, Hill Country MHDD Centers will:

A) *Assess size, characteristics and needs of individuals with mental illness identified with frequent utilization of the Emergency Department, the Criminal Justice system, or Psychiatric Inpatient settings*, Hill Country will work with the local court systems to identify a target population that would gain the greatest benefit from participating in a mental health court to determine the size and characteristics of the population to be served. Hill Country will also review with the court the Sequential Intercept Model to determine the most appropriate level of entry for participants.

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.* Hill Country will visit successful mental health courts and review literature on lessons learned from other mental health courts in order to develop targeted services, forms and procedures in establishing the mental health courts and associated services.

C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment (DLA-20).

D) *Design models which include an appropriate range of community-based services and residential supports.* . Based on the size, characteristics and needs for the target population, Hill Country will train staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community. .

E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the ANSA and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of Mental Health Court participants. In addition, Hill Country will do follow up surveys with individuals who receive Mental Health Court services to determine satisfaction with services and to help ensure stabilization of symptoms.

Reason for Selection of Milestones and Metrics

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are

essential during DY2. The DY3 milestone concentrates on number of individuals beginning service to ensure the project is operational during DY3. DY4 and DY5 have number of new individuals beginning service and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique community need identification number the project addresses:
CN.4 Inadequate access to behavioral health care
CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Hill Country MHDD Centers currently does not have any Mental Health Courts within its service area.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure
Increased treatment compliance through Mental Health Courts impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

How Project Supports, Reinforces, Enables Other Projects

Provision of Mental Health Court Services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services and 1333040307.4 Trauma Informed Care, 133340307.2.5 Veteran Mental Health Services, 133340307.2.6 Children's Mental Health Crisis Respite Center, 133340307.2.7 Children's Mental Health Trauma Services, 133340307.2.9 Whole Health Peer Support, 133340307.2.10 Adolescent Whole Health Peer Support, 133340307.2.11 Family Partner and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provide mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

126844305.2.3 – Bluebonnet Trails Community Services - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population, criminal justice systems: Services for Justice-Involved Youth and Adults: Bastrop, Caldwell, Fayette and Lee Counties

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation

137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

Hill Country MHDD Centers will participate in a learning collaborative that meets semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

The valuation on this project is based on an estimated 125 individuals receiving mental health court services over the life of the project.

133340307.2.8	***2.13.1***	***2.13.1 A-E***	Project Option 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.9*	*IT 10.2*	*Activities of Daily Living (DLA-20)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population (Mental Health Courts) Metric 1 P-2.1: Project plans which are based on evidence/experience and which address the project goals Baseline: No intervention has been designed Goal: Submission of project plan Data Source: Project documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $452,729	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health Court) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 25 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $466,259**	**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records, project reports Milestone 4 Estimated Incentive Payment: $ 235,177 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health Court)	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records, project reports Milestone 4 Estimated Incentive Payment: $ 240,756 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Mental Health Court)

		Baseline/Goal: Baseline - 0 individuals served; Goal - 40 individuals beginning service during DY4 (total of 65) **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $235,176**	**Baseline/Goal**: Baseline - 0 individuals served; Goal - 60 individuals beginning service during DY5 (total of 125) **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $240,756**
Year 2 Estimated Milestone Bundle Amount: $452,729	Year 3 Estimated Milestone Bundle Amount: $466,259	Year 4 Estimated Milestone Bundle Amount: $470,353	Year 5 Estimated Milestone Bundle Amount: $481,512
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,870,853			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Adult Whole Health Peer Support

133340307.2.9 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will implement Whole Health Peer Support services within Hays County served by Hill Country in RHP7 in order to meet the overall health needs of individuals who have behavioral health issues. The project will identify and train behavioral health peers on whole health risk assessments and working with peers to address overall health issues in order to treat symptoms prior to the need for utilization of emergency departments or inpatient hospitalization.

Need for the project: According to SAMHSA, individuals with severe and persistent mental illness die 25 years earlier than the general population. Identifying and addressing overall health symptoms, such as hypertension, diabetes, obesity, tobacco use and physical inactivity, of individuals with severe and persistent mental illness helps address this issue while reducing emergency department utilization and potentially preventable admissions to hospitals.

Target population: The target population is individuals within Hays County who have severe and persistent mental illness and other health risk factors. There are currently 1,044 individuals identified that meet target population. Based on the population served in Hill Country's behavioral health program in RHP7, it is anticipated that approximately 30% of our behavioral health patients within RHP7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project seeks to provide services to a minimum of 116 individuals from Hays County served by Hill Country in RHP7 by the end of DY5 (number beginning service by DY: DY3 25; DY4 40; and DY5 51).

Category 3 outcomes IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Whole Health Peer Support showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization.

Title of Project: Recruit, train and support consumers of mental health services to provide peer support services - Adult Whole Health Peer Support

Project Option: 2.18.1

RHP Project Identification Number: 133340307.2.9 Pass 2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

In order to reemphasize the importance of peer support services, to fully integrate peer support services into the network of services provided through the Hays Mental Health Clinic operated by Hill Country MHDD Centers within RHP7 and to expand the peer support services offered to include whole health interventions including health risk assessments, Hill Country will recruit additional peer specialists, arrange for appropriate training, and emphasis the peer specialists roles regarding whole health and serving as navigator for consumers.

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide are supportive in nature. By expanding peer services as an integral portion of the Hays Mental Health Clinic operated by Hill Country MHDD Centers and including whole health risk assessments and supported services targeted to individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved. Addressing these issues addresses the disparate life expectancy and poor health outcomes of individuals with mental illness and ultimately decreases utilization of Emergency Departments.

Hill Country is planning to utilize consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide behavioral health services to their peers. Through Via Hope, a state wide organization established under the State's Mental Health Transformation grant, consumers are trained to serve as whole health peer support specialists. Upon completion of training, peers are working with consumers to set achievable goals to prevent chronic diseases such as diabetes or to address when they exist. While Hill Country has begun the process of incorporating peer support services, there have been challenges with maintaining peer support specialists and fully incorporating peer services throughout the treatment process. The advancement to Whole Health Peer Support is needed along with increased emphasis on the importance and impact of peer services in order to help individuals advance in their recovery. Hill Country anticipates serving a minimum of 120 individuals through Whole Health Peer Support during the project period.

In implementing this project, Hill Country will continue to train and educate clinicians on the importance of peer services, recruit and train peer specialists in the provision of Whole Health Peer Support, and utilize peer services to identify health risks and provide appropriate education and referrals regarding the health risks identified. Peer services will be tracked in Hill Country's information technology system

(Anasazi) by location and consumer in order to monitor services delivered and outcomes of the services. In addition, Hill Country will conduct consumer satisfaction surveys for individuals receiving peer support services.

Challenges or Issues Faced by the Performing Provider

The challenges Hill Country has faced in establishing a robust peer support program have been in relation to retaining individuals in the positions for extended periods of time. Hill Country plans to address this challenge by shifting the focus of peer support to a whole health model, focusing on the individual's mental and physical well being, that becomes more fully integrated into the regular practice of the mental health clinics. In addition, Hill Country intends to increase the percentage of full time equivalent for peer support specialists in order to increase retention.

Project Goals

By the end of five years, Hill Country's goal is to have peer support specialists at the Hays County Mental Health clinic with a minimum full time equivalency of 2.0 and to have 20% of the consumers who participate in whole health peer support experiencing improvement on the DLA-20. Currently, Hill Country has 0.06 full time equivalency for peer support services at the Hays County Mental Health Clinic within RHP7.

Relationship to the Regional Goals

The goal of this project is to use Whole Health Peer Support to provide guidance and support for the consumer's journey of recovery based on each individual's needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goals of:

3 Improve the patient experience of care by investing in patient centered, integrated, comprehensive care that is coordinated across systems, and

6 Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data Hill Country MHDD Centers has utilized Peer Specialists in a limited capacity over the past seven years as a means to help support individuals with behavioral health issues deal with their symptoms and advance in their recovery. Hill Country MHDD Centers currently has ten peer specialists throughout the 19 county service area with only four certified through the state training program. The Hays Mental Health Clinic within RHP7 currently has .06 full-time equivalency (2.4 hours per week) for provision of peer support services. In order to reemphasize the importance of peer support services, to fully integrate peer support services into the network of services provided through the Hays Mental Health Clinic operated by Hill Country MHDD Centers within RHP7 and to expand the peer support services offered to include whole health interventions including health risk assessments, Hill Country will recruit additional peer specialists, arrange for appropriate training, and emphasis the peer specialists roles regarding whole health and serving as navigator for consumers

Rationale

Reason for Selection of Project Options and Components

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide and supportive in nature. By expanding peer services as an integral portion of the Hays County Mental Health Clinic operated by Hill Country MHDD Centers and including whole health risk assessments and supported services targeted to

individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of Emergency Departments. Through this project Hill Country will acquire and maintain Whole Health Peer Support Specialists equivalent to a minimum of 2.0 full time equivalency (80 hours per week) at the Hays County Mental Health Clinic operated by Hill Country within RHP7.

Project Components:
Through the Whole Health Peer Support, Hill Country MHDD Centers proposes to meet all required project components.

A) *Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.* Hill Country MHDD Centers is currently participating in the Person Centered Recovery Initiative through Via Hope. The initiative is designed to promote mental health system transformation by 1) helping organizations develop culture and practices that support and expect recovery, and 2) promoting consumer voice in the transformation process and the future, transformed mental health system. On October 24th, 2012, the clinical leadership of Hill Country completed a one day training on integrating peer support and incorporating the patient in developing and implementing their treatment plan.
B) *Conduct readiness assessments of organization that will integrate peer specialists into their network.* Hill Country will review readiness at the Llano Mental Health Clinic within RHP8 and address any potential barriers to full integration of Whole Health Peer Support.
C) *Identify peer specialists interested in this type of work.* Hill Country will recruit peer specialists who have interest, first and foremost, in helping other on their journey of recovery and who also wish to receive training in providing whole health peer services and are interested in employment with Hill Country MHDD to provide whole health peer services.
D) *Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity).* Hill Country MHDD Centers will make arrangements for interested peer specialists to attend Whole Health Peer Support trainings and certifications available through the state of Texas Via Hope program. If training space becomes restrictive, Hill Country will find or develop similar training to bring peer specialists on board until such time as the certification training is available.
E) *Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.* Hill Country MHDD Centers will have trained peer specialists utilize the health risk assessment tool to determine potential or current health risks, will track the completion of health risk assessments in the information technology system, and will address potential health risks with the patient.
F) *Identify patients with serious mental illness who have health risk factors that can be modified.* Patients identified through the health risk assessment tool will receive education and information regarding potential health risks and, if appropriate, referred to primary care and preventive resources.
G) *Implement whole health peer support.* Hill Country will track the occurrence of health risk assessments by location and patient in order to determine the project is fully implemented.
H) *Connect patient to primary care and preventive services.* If risk factors or medical conditions are identified that require more than basic education, individuals will be referred to the appropriate primary care and preventive services.
I) *Track patient outcomes Review the intervention(s) impact on participants and identify "lessons learned," opportunities to scale all or part of the interventions(s) to a broader patient population, and identify key challenges*

associated with expansion of the intervention(s), including special considerations for safety-net populations. Hill Country will utilize the Daily Living Activities assessment to determine progression of individuals receiving Whole Health Peer Support services. In addition, Hill Country will do follow up surveys with individuals who receive Whole Health Peer Support services to determine satisfaction with services and to help ensure stabilization of symptoms

Unique community need identification number the project addresses:
CN.4 Inadequate access to behavioral health care
CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Current levels of service are too low and not focused on whole health models of care.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure

Whole Health Peer Support services impact an individual's mental and physical health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living (DLA-20) will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug

Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

How Project Supports, Reinforces, Enables Other Projects

Provision of Veteran Mental Health Services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services and 133340307.4 Trauma Informed Care, 133340307.2.5 Veteran's Mental Health, 133340307.2.6 Children's Mental Health Crisis Respite Center, 133340307.2.7 Children's Mental Health Trauma Services, 13340307.2.8 Mental Health Court, 133340307.2.10 Adolescent Whole Health Peer Support, 133340307.2.11 Family Partner and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions.

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provide mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

133542405.2.6 - Austin Travis County Integral Care - Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services

201320302.2.2 - City of Austin Health & Human Services Department - Expansion of Community Diabetes Project

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

Hill Country MHDD Centers will participate in a learning collaborative that meets semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region

Rationale/Justification for Valuation

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by 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 area avoided). The proposed program's value is based on the average of benefit-cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of $23.36 for every dollar invested. "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

133340307.2.9	***2.18***	***2.18.1 A-I***	Recruit, train and support consumers of mental health services to provide peer support services Whole Health Peer Support
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.10*	*IT 10.2*	*Activities of Daily Living (DLA-20)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-3: Identify and train peer specialists to conduct whole health classes <u>Metric 1</u> P-3.1: Number of peers trained in whole health planning Goal: 4 peers trained in whole health planning during DY2 Data Source: Training records Milestone 1 Estimated Incentive Payment *(maximum amount):* $397,951	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Adult Whole Health Peer Support) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 25 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $409,844**	**Milestone 3** P-7: Evaluate and continuously improve peer support services <u>Metric 1</u> P-7.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 4 3 Estimated Incentive Payment: $ 206,721 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Adult Whole Health Peer Support)	**Milestone 5** P-7: Evaluate and continuously improve peer support services <u>Metric 1</u> P-7.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 4 5 Estimated Incentive Payment: $ 211,626 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Adult Whole Health Peer Support)

		Baseline/Goal: Baseline - 0 individuals beginning service in DY2; Goal – 40 new individuals beginning services during DY4 (for a total of 65); **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $206,721**	**Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 51 new individuals beginning services during DY5 (for a total of 116); **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $211,625**
Year 2 Estimated Milestone Bundle Amount: $397,951	Year 3 Estimated Milestone Bundle Amount: $409,844	Year 4 Estimated Milestone Bundle Amount: $413,442	Year 5 Estimated Milestone Bundle Amount: $423,251
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,644,488			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Adolescent Whole Health Peer Support

133340307.2.10 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012

Intervention(s): This project will implement Adolescent Whole Health Peer Support services within Hays County served by Hill Country in RHP7 in order to meet the overall health needs of adolescents who have behavioral health issues. The project will identify and train adolescent behavioral health peers on whole health risk assessments and working with peers to address overall health issues in order to treat symptoms prior to the need for utilization of emergency departments or inpatient hospitalization.

Need for the project: According to SAMHSA, individuals with severe and persistent mental illness die 25 years earlier than the general population. Identifying and addressing overall health symptoms, such as hypertension, diabetes, obesity, tobacco use and physical inactivity, of individuals with severe and persistent mental illness helps address this issue while reducing emergency department utilization and potentially preventable admissions to hospitals. In *Relations Between Social Support and Physical Health,* Corey Clark from Rochester Institute of Technology notes that peer support is a very important factor for adolescents and is an alternate method of getting social support and that social support is very essential for adolescents to become successful with themselves.

Target population: The target population is adolescents within Hays County who have severe and persistent mental illness and other health risk factors. There are currently 273 individuals identified that meet target population. Based on the population served in Hill Country's behavioral health program in RHP7, it is anticipated that approximately 30% of our behavioral health patients within RHP7 have Medicaid and approximately 75% have income below $15,000 per year.
Category 1 or 2 expected patient benefits: The project seeks to provide services to a minimum of 88 adolescents from Hays County served by Hill Country in RHP7 by the end of DY5 (number beginning service by DY: DY3 20; DY4 30; and DY5 38).

Category 3 outcomes IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Whole Health Peer Support showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization.

Title of Project: Recruit, train and support consumers of mental health services to provide peer support services - Adolescent Whole Health Peer Support

Project Option: 2.18.1

RHP Project Identification Number: 133340307.2.10 Pass 2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

Through this project Hill Country will develop an Adolescent Whole Health Peer Support Network in order to help adolescents deal with the unique challenges at their stage of life and assist with the transition to adulthood.

Hill Country is planning to utilize consumers of adolescent mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide Adolescent Whole Health Peer Support. Through Via Hope, a state wide organization established under the State's Mental Health Transformation grant, consumers are being trained to serve as whole health peer support specialists. Upon completion of training, peers are working with consumers to set achievable goals to prevent chronic diseases such as diabetes or to address when they exist. While Hill Country has begun the process of incorporating peer support services, there have been challenges with maintaining peer support specialists and fully incorporating peer services throughout the treatment process. The advancement to Whole Health Peer Support is needed along with increased emphasis on peer services in order to help individuals advance in their recovery. To date, Hill Country has only concentrated on Adult Peer Support and has not had an emphasis on Adolescent Whole Health Peer Support.

In implementing this project, Hill Country will train and educate clinicians on the importance of adolescent peer services, recruit and train adolescent peer specialists in the provision of Adolescent Whole Health Peer Support, and utilize adolescent peer services to identify health risks and provide appropriate education and referrals regarding the health risks identified. Adolescent peer services will be tracked in Hill Country's information technology system (Anasazi) by location, age and consumer in order to monitor services delivered and outcomes of the services. In addition, Hill Country will conduct consumer satisfaction surveys for individuals receiving adolescent peer support services.

In *Relations Between Social Support and Physical Health,* Corey Clark from Rochester Institute of Technology notes that peer support is a very important factor for adolescents and is an alternate method of getting social support and that social support is very essential for adolescents to become successful with themselves. In *Differential effects of support providers on adolescents' mental health,* Lisa Colarossi and Jacquelynee Eccles reported that research repeatedly shows that social support has both direct and indirect effects on mental health and academic outcomes, such that support can have multiple influences across multiple contexts. Support leads to mutual assistance, feelings of self-worth, and self-efficacy and helps in cognitive development by providing stimulus, promoting intellectual advances, and framing pro-social expectations.

In the Policy Brief, *Supporting Transition to Adulthood Among Youth with Mental Health Needs: Action Steps for Policymakers* published by National Collaborative on Workforce and Disability for Youth, it is noted that programs should have implementation strategies that clarify and incorporate the youth voice across the continuum of empowerment – youth driven, youth directed, and youth guided. This implementation strategy is further emphasized as one of the key principles in the promising practice Transition to Independence Process which ensures a safety net of support by involving a young person's parents, family members, and other informal and formal key players and involving young people, parents, and other community partners in the system at the practice, program and community levels. Through Adolescent Whole Health Peer Support, Hill Country plans to develop a formal network of support for Adolescents dealing with mental health issues.

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide and supportive in nature, especially for adolescents. By expanding peer services as an integral portion of the mental health services operated by Hill Country MHDD Centers and including whole health risk assessments and supported services targeted to adolescents with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of Emergency Departments.

Challenges or Issues Faced by the Performing Provider

The challenges Hill Country has faced in establishing a robust peer support program have been in relation to retaining individuals in the positions for extended periods of time. Hill Country plans to address this challenge by shifting the focus of peer support to a whole health model that becomes more fully integrated into the regular practice of the mental health clinics and by adding a specific emphasis on adolescent peer support services. In addition, Hill Country intends to increase the percentage of full time equivalent for peer support specialists in order to increase retention.

Project Goals

By the end of five years, Hill Country's goal is to have adolescent peer support specialists with a minimum full time equivalency of 2.0 and to have 20% of the consumers who participate in adolescent whole health peer support experiencing improvement on the DLA-20. Currently, Hill Country has .06 full time equivalency for peer support services at the Hays County Mental Health Clinic within RHP7 and no dedicated resources to adolescent peer support.

Relationship to the Regional Goals

The goal of this project is to use Adolescent Whole Health Peer Support to provide guidance and support for the consumer's journey of recovery based on each individual's needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goals of:

3 Improve the patient experience of care by investing in patient centered, integrated, comprehensive care that is coordinated across systems, and

6 Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data Hill Country MHDD Centers has utilized Peer Specialists in a limited capacity over the past seven years as a means to help support individuals with behavioral health issues deal with their symptoms and advance in their recovery but has never had an emphasis on Adolescent Whole Health Peer Support. Currently, Hill Country MHDD Centers has ten peer specialists with only four having certification through the state training program. The Hays Mental Health Clinic within RHP7 currently has.06 full-time equivalency (2.4 hours per week) for provision of peer support services and no dedicated resources for Adolescent Peer Support. In order to emphasize the importance of adolescent peer support services, to fully integrate peer support services into the network of services provided through the Hays Mental Health Clinic operated by Hill Country MHDD Centers within RHP7 and to begin adolescent peer support services offered to include whole health interventions including health risk assessments, Hill Country will recruit adolescent peer specialists, arrange for appropriate training, and emphasis the adolescent peer specialists roles regarding whole health and serving as navigator for consumers.

Rationale

Reason for Selection of Project Options and Components

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide and supportive in nature. Currently there are no Adolescent Whole Health Peer Support services available in Hays County. Through this project Hill Country will acquire and maintain Adolescent Whole Health Peer Support Specialists equivalent to a minimum of 2.0 full time equivalency operated by Hill Country.

Project Components:

Through the Adolescent Whole Health Peer Support, Hill Country MHDD Centers proposes to meet all required project components.

A) *Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system.* Hill Country MHDD Centers is currently participating in the Person Centered Recovery Initiative through Via Hope. The initiative is designed to promote mental health system transformation by 1) helping organizations develop culture and practices that support and expect recovery, and 2) promoting consumer voice in the transformation process and the future, transformed mental health system. On October 24th, 2012, the clinical leadership of Hill Country completed a one day training on integrating peer support and incorporating the patient in developing and implementing their treatment plan.

B) *Conduct readiness assessments of organization that will integrate peer specialists into their network.* Hill Country will review readiness at the mental health clinic and address any potential barriers to full integration of Adolescent Whole Health Peer Support.

C) *Identify peer specialists interested in this type of work.* Hill Country will recruit adolescent peer specialists who have interest, first and foremost, in helping other adolescents on their journey of recovery and who also wish to receive training in providing whole health peer services and are interested in employment with Hill Country MHDD to provide whole health peer services.

D) *Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity).* Hill Country MHDD Centers will make arrangements for interested adolescent peer specialists to attend Whole Health Peer Support trainings and certifications available through the state of Texas Via Hope program.

If training space becomes restrictive, Hill Country will find or develop similar training to bring peer specialists on board until such time as the certification training is available.

E) *Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.* Hill Country MHDD Centers will have trained peer specialists utilize the health risk assessment tool to determine potential or current health risks, will track the completion of health risk assessments in the information technology system, and will address potential health risks with the patient.

F) *Identify patients with serious mental illness who have health risk factors that can be modified.* Patients identified through the health risk assessment tool will receive education and information regarding potential health risks and, if appropriate, referred to primary care and preventive resources.

G) *Implement whole health peer support.* Hill Country will track the occurrence of health risk assessments by location and patient in order to determine the project is fully implemented.

H) *Connect patient to primary care and preventive services.* If risk factors or medical conditions are identified that require more than basic education, individuals will be referred to the appropriate primary care and preventive services.

I) *Track patient outcomes Review the intervention(s) impact on participants and identify "lessons learned," opportunities to scale all or part of the interventions(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* Hill Country will utilize the Daily Living Activities assessment to determine progression of individuals receiving Whole Health Peer Support services. In addition, Hill Country will do follow up surveys with individuals who receive Whole Health Peer Support services to determine satisfaction with services and to help ensure stabilization of symptoms

Unique community need identification number the project addresses:

CN.4 Inadequate access to behavioral health care

CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

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

Hill Country MHDD Centers has utilized Peer Specialists in a limited capacity over the past seven years as a means to help support individuals with behavioral health issues deal with their symptoms and advance in their recovery but has not implemented an adolescent peer support network. The Hays County Mental Health Clinic currently has .06 full-time equivalency of peer support services. In order to reemphasize the importance of peer support services, to fully integrate peer support services into the network of services provided through the Hays County Mental Health Clinic operated by Hill Country MHDD Centers within RHP7 and to expand the peer support services offered to include adolescent whole health peer interventions including health risk assessments, Hill Country will recruit adolescent peer specialists, arrange for appropriate training, and emphasis the adolescent peer specialists roles regarding whole health and serving as navigator for consumers.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure

Adolescent Whole Health Peer Support services impact an individual's mental and physical health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living (DLA-20) will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

How Project Supports, Reinforces, Enables Other Projects

Provision of Veteran Mental Health Services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services and 133340307.4 Trauma Informed Care, 133340307.2.5 Veteran's Mental Health, 133340307.2.6 Children's Mental Health Crisis Respite Center, 133340307.2.7 Children's Mental Health Trauma Services, 13340307.2.8 Mental Health Court, 133340307.2.9 Whole Health Peer Support, 133340307.2.11 Family Partner and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7. The other two local mental health authorities (Austin Travis

County Integral Care and Bluebonnet Trails) provide mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

133542405.2.6 - Austin Travis County Integral Care - Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services

201320302.2.3 - City of Austin Health & Human Services Department - Prevention and Cessation Program for 18-24 years olds in Travis County

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by 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 area avoided). The proposed program's value is based on the average of benefit-cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of $23.36 for every dollar invested. "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

133340307.2.10	***2.18***	***2.18.1 A-I***	Recruit, train and support consumers of mental health services to provide peer support services Adolescent Whole Health Peer Support
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.11*	*IT 10.2*	*Activities of Daily Living (DLA-20)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-3: Identify and train peer specialists to conduct whole health classes <u>Metric 1</u> P-3.1: Number of peers trained in whole health planning Goal: 3 peers trained in whole health planning during DY2 Data Source: Training records Milestone 1 Estimated Incentive Payment *(maximum amount):* $298,463	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Adolescent Whole Health Peer Support) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 20 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $307,382**	**Milestone 3** P-4: Evaluate and continuously improve peer support services <u>Metric 1</u> P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 4 Estimated Incentive Payment: $ 155,041 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Adolescent Whole Health Peer	**Milestone 5** P-4: Evaluate and continuously improve interventions <u>Metric 1</u> P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 4 Estimated Incentive Payment: $ 158,719 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Adolescent Whole Health Peer Support)

		Support) **Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 30 new individuals beginning services during DY4 (for a total of 50); **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $155,040**	**Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 38 new individuals beginning services during DY5 (for a total of 88); **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $158,719**
Year 2 Estimated Milestone Bundle Amount: $298,463	Year 3 Estimated Milestone Bundle Amount: $307,382	Year 4 Estimated Milestone Bundle Amount: $310,081	Year 5 Estimated Milestone Bundle Amount: $317,438
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,233,364			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Family Partner Program

133340307.2.11 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012.

Intervention(s): This project will implement a Family Partner Program within Hays County that will meet the overall health needs of children dealing with behavioral health issues in order to limit stressors in the family and to aid in the child's recovery. The Family Partner will provide peer mentoring and support to the primary caregivers; introduce the family to the treatment process; model self-advocacy skills; provide information, referral and non-clinical skills training; assist in the identification of natural/non-traditional and community support systems; and document the provision of all family partner services, including both face-to-face and non face-to-face activities.

Need for the project: Family Partner services are essential to serve as advocates for families who are dealing with behavioral issues with their children. Identifying and accessing assistance programs are challenging and are especially challenging for families who are constantly dealing with behavioral issues of their children. Through this project Hill Country anticipates serving an additional 200 families through Family Partner services.

Target population: The target population will include: stressful home situations; situations where the family environment may be exacerbating symptoms; single parents homes; low income families that need assistance accessing services; grandparents serving as foster parents; and families needing to transition from Early Childhood Intervention to children's mental health services. Hill Country currently provides behavioral health services to 256 children in Hays County and this project would make Family Partner services available to these families as well as to other families identified by the local schools. Based on the population served in Hill Country's behavioral health program in RHP7, approximately 30% of our behavioral health patients within RHP7 have Medicaid and approximately 75% have income below $15,000 per year.

Category 1 or 2 expected patient benefits: The project aims to establish Family Partner Services to serve Hays County within RHP7. The Family Partner will provide support to families who have children with mental illness or behavioral issues. The project seeks to provide services to a minimum of 225 individuals in RHP7 by the end of DY5 (number beginning service by DY: DY3 30; DY4 85; DY5 110).

Category 3 outcomes IT-10.2 Activities of Daily Living (DLA-20) Our goal is to have, at a minimum, 20% of the individuals served by the Family Partner Services showing improvement on the Activities of Daily Living (DLA-20) which demonstrates stabilizing the individual in the community thus reducing the need for inpatient hospitalization and emergency department utilization.

Title of Project: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Family Partner Services

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

RHP Project Identification Number: 133340307.2.11 Pass 2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Performing Provider TPI: 133340307

Project Description

Overall Project Description

The approach Hill Country will take with this project will be to expand Family Partner Services to provide support to families who have children with mental illness or behavioral issues. The target population will include: stressful home situations; situations where the family environment may be exacerbating symptoms; single parents homes; low income families that need assistance accessing services; grandparents serving as foster parents; and families needing to transition from Early Childhood Intervention to children's mental health services. During the last year, Hill Country provided Family Partner services to 46 families (35 from Comal County and 11 from Hays County). This project would expand the Family Partner service throughout Hays County in RHP7. Hill Country currently provides behavioral health services to 256 children in Hays County and this project would make Family Partner services available to these families as well as to other families identified by the local schools.

Family Partners are the parent or Legally Authorized Representative of a child or youth with a serious emotional disturbance and have at least one year of experience navigating a child-serving system (e.g. mental health, juvenile justice, social security, special education). They provide peer mentoring and support to the primary caregivers; introduce the family to the treatment process; model self-advocacy skills; provide information, referral and non-clinical skills training; assist in the identification of natural/non-traditional and community support systems; and document the provision of all family partner services, including both face-to-face and non face-to-face activities.

Family Partners incorporate their unique life experiences gained through parenting a child whose emotional and/or behavioral challenges required accessing resources, services and supports from multiple child-serving systems as they progressed toward achievement of the family's goals. Sharing information, support and advocacy with one another is vital for families overcoming the challenges of raising and supporting a child with emotional, mental or behavioral disorders.

In 2003, the President's New Freedom Commission on Mental Health issued "*Achieving the Promise: Transforming Mental Health Care in America*". Goal 2 of that report calls for "consumer and family driven care." The report cites research showing that hope and self-determination play a key role in recovery. The Commissioners insisted that families "must stand at the center of the system of care." The Family Partner project will build on this concept by implementing the following core functions: Advocacy (define and explain family driven care; explain concept of strength-based approach to recovery; active and empathetic listening; referring to local resources); Professional Responsibility (principles of recovery; cultural

competence; accountability; confidentiality); Mentoring(peer relationship; social learning; respectful, trusting relationship; active and empathetic listening; relevance of outcomes; explain roles of clinicians and parents; share own family's recovery); Family Support(identify natural support system; identify and discuss treatment options; help parents identify community norms around child-rearing; define resilience); and Child and Adolescent Development (understand child development stages; value of Social and Emotional Learning; importance of early intervention; problem-solving process).

Through this project Hill Country will identify and train Family Partners in supporting and helping other families who have children with mental or emotional disorders navigate the system of care in order to aid the family and child in their resilience and recovery.

Challenges or Issues Faced by the Performing Provider

The primary challenge for implementation of the project is identifying families who have the time and skill set necessary to support other families as they navigate the system of care. Hill Country will address the challenge by offering incentives as necessary. In addition, Hill Country will overcome the challenge of identifying families that would benefit from the service by reviewing current children receiving behavioral health services and by working with the local school districts to identify families that need additional support in dealing with behavioral issues.

Project Goals

The goal of this project is to expand Family Partner Services throughout the 19 counties served by Hill Country. The primary challenge of the project will be recruitment and training of family members for initial implementation. By the end of five years, Hill Country's goal is to establish Family Partner Services and to provide services to at least 225 families of children with mental or emotional issues within the community over the life of the project. Hill Country anticipates hiring and training at least 5 family partners to complete the project.

Relationship to the Regional Goals

The goal of this project is to provide Family Partner Services within the community setting. By providing these services in the community, Hill Country will be meeting RHP 7's Regional Goal 6, of expanding access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data

Hill Country currently provides Family Partner Services to 46 families per year. Through this initiative, Hill Country plans to provide Family Partner Services to an additional 225 families by the end of DY5. This program would enable Hill Country to provide Family Partner services to families of a broad child population at an early stage to avoid the exacerbation of symptoms into a crisis episode resulting in utilization of Emergency Departments, potential psychiatric hospitalizations and utilization of the criminal justice system.

Reason for Selection of Project Options and Components

Family Partner services are essential to serve as advocates for families who are dealing with behavioral issues with their children. Identifying and accessing assistance programs are challenging and are especially

challenging for families who are constantly dealing with behavioral issues of their children. Through this project Hill Country anticipates serving an additional 225 families through Family Partner services.

The approach Hill Country will take with this project will be designing programs to offer Family Partner focused services in order to help families acquire appropriate resources and means to address and support their situation in dealing with their child's mental and emotional distress in order to aid in resilience and recovery.

Project Components:

Through the implementation of Family Partner Services, Hill Country MHDD Centers proposes to meet all required project components:

A) *Assess size, characteristics and needs of target population.* Hill Country will collect and analyze information on families with children who have mental and emotional disturbances and review contributing factors such as homelessness, noncompliance with medication, diagnosis, unemployment, economic struggles and other factors contributing to symptoms in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations for service providers.

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.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving families with children with mental illness in order to provide targeted training for staff and to develop innovative wrap around services to help avert future impact of the symptoms.

C) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the issues leading to the trauma, the services received, the number of individuals receiving follow up services, the number of individuals with recurring symptoms, and progression on the Activities of Daily Living assessment (DLA-20).

D) *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train Family Partners in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

E) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of individuals receiving Family Partner services. In addition, Hill Country will do follow up surveys with individuals who receive services to determine satisfaction with services and to help ensure stabilization of symptoms.

Reason for Selection of Milestones and Metrics

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are

essential during DY2. The DY3 milestone concentrates on number of individuals beginning service to ensure the project is operational during DY3. DY4 and DY5 have number of new individuals beginning service and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique community need identification number the project addresses:

CN.4 Inadequate access to behavioral health care
CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

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

Hill Country currently has one Family Partner who serves 46 families per year with 35 of the families in Comal County and only 11 of the families in Hays County. The expansion of Family Partner Services will enable the commitment of trained staff to provide ongoing Family Partner services throughout Hill Country's 19 county service area in order to reduce the number of psychiatric hospitalizations and avert recurrence of the psychiatric crisis due to triggers related to past trauma.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected
OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living

Reasons/rationale for selecting the outcome measure

Family Partner Services impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

How Project Supports, Reinforces, Enables Other Projects

Provision of Child Trauma Informed Care services for children with mental health disorders as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services, 133340307.4 Trauma Informed Care, 133340307.2.5 Veteran's Mental Health, 133340307.2.6 Child Mental Health Crisis Center, 133340307.2.7 Child Trauma Informed Care; 13340307.2.8 Mental Health Court, 133340307.2.9 Whole Health Peer Support, 133340307.2.10 Adolescent Whole Health Peer Support, and 133340307.2.12 Hays County Psychiatric Consultation) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3)

Relationship to Other Performing Providers' Projects in the RHP

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7. The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provides mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

133542405.2.6 - Austin Travis County Integral Care - Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services

201320302.2.5 - City of Austin Health & Human Services Department - Healthy Families Program Expansion

137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department

Plan for Learning Collaborative

Hill Country MHDD Centers will participate in a learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 200 individuals receiving Family Partner services over the life of the project.

133340307.2.11	***2.13.1***	***2.13.1 A-E***	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Family Partner
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.12*	*IT 10.2*	*Activities of Daily Living (DLA-20)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design community-based specialized intervention for target population Metric 1 P-2.1: Project plans which are based on evidence/experience and which address the project goals Goal: Submission of project plan Data Source: Project Plan documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $766,867	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Family Partner Services) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 30 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $789,785**	**Milestone 3** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 3 Estimated Incentive Payment: $ 398,360 **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Family Partner Services) **Baseline/Goal**: Baseline - 0 individuals served in DY2; Goal - 85	**Milestone 5** P-4: Evaluate and continuously improve interventions Metric 1 P-4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Documentation of how monthly real-time data is used for rapid-cycle improvement to guide continuous quality improvement Data Source: Hill Country MHDD records Milestone 5 Estimated Incentive Payment: $407,810 **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Family Partner Services) **Baseline/Goal**: Baseline - 0 individuals served in DY2; Goal - 110

		individuals beginning service during DY4 **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $398,359**	individuals beginning service during DY5 **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $407,810**
Year 2 Estimated Milestone Bundle Amount: $766,867	Year 3 Estimated Milestone Bundle Amount: $789,785	Year 4 Estimated Milestone Bundle Amount: $796,719	Year 5 Estimated Milestone Bundle Amount: $815,620
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,168,991			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

Hays County Virtual Psychiatric and Clinical Guidance

133340307.2.12 Pass 2

Provider: Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to Hays County of RHP 7: Hill Country serves a 678 square mile area of RHP 7 with a population of approximately 179,519 in 2012.

Intervention(s): This project will implement psychiatric and clinical guidance 24 hour a day, 7 day a week for primary care physicians and hospitals within Hays County served by Hill Country in RHP 7 to help physicians identify and treat behavioral health symptoms earlier to avoid exacerbation of symptoms into a behavioral health crisis.

Need for the project: There are currently no dedicated resources for behavioral health consultation available to hospitals and primary care physicians within Hays County.

Target population: The target population is individuals within Hays County who demonstrate behavioral health symptoms and seek treatment at area hospitals or with their primary care physician. Based on a 12-month mental illness prevalence of 26.2% as reported by the National Institute of Mental Health, the target population consists of approximately 47,000 individuals. Based on the population served in Hill Country's behavioral health program in RHP 7, it is anticipated that approximately 30% of patients within RHP 7 have Medicaid and approximately 75% have income below $15,000 per year.
Category 1 or 2 expected patient benefits: The project seeks to provide 2,000 psychiatric consultations by the end of DY5 for Hays County served by Hill Country in RHP 7 (250 during DY3; 750 during DY4; and 1,00 during DY5)

Category 3 outcomes

OD-12 Primary Care and Primary Prevention (Description from the narrative)

- IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC): The number of PHQ-A/BDI-PC performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the 12 to 18 year population of Blanco and Llano counties as determined by DSHS' population estimates.
- IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9): The number of PHQ-9 performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Blanco and Llano counties as determined by DSHS' population estimates.
- IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT): The number of CAGE/AUDIT performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Blanco and Llano counties as determined by DSHS' population estimates.

Title of Project: Hays County Virtual Psychiatric and Clinical Guidance

Project Option: 2.16.1 Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hays County Virtual Psychiatric and Clinical Guidance

RHP Project Identification Number: 133340307.2.12 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Project Description

Overall Project Description

According to *Mental Health Care by Family Physicians,* a paper prepared by the American Academy of Family Physicians, "Mental health issues are frequently unrecognized and even when diagnosed are often not treated adequately. Recognition and treatment of mental illness are significant issues for primary care physicians, who provide the majority of mental health care. In a recent national survey of mental health care, 18% of the surveyed population with and without a DSM-IV diagnosis of a mental health disorder sought treatment during a 12 month period, with 52% of those visits occurring in the general medical (all primary care) sector. Estimates are that 11% to 36% of primary care patients have a psychiatric disorder, with one recent survey of mental health conditions in urban family medicine practices revealing that over 40% of survey respondents met criteria for a mental health disorder."

Recognition and treatment of mental illness are significant issues for primary care physicians, who provide the majority of mental health care. There is a need to develop Psychiatric Consultation services and have them available for Primary Care Physicians and hospitals throughout the region to assist with complex psychiatric needs within Hays County.

In establishing the project, Hill Country will identify primary care physicians and hospitals within Hays County where patients would receive the greatest benefit, determine needed telecommunication equipment based on anticipated volume of service, and recruit and hire appropriate clinical staff with the expertise to provide remote psychiatric consultative services. After reviewing models for deployment that have been successful in other areas, Hill Country will work with primary care physicians and hospitals to determine the most appropriate method for consultative service delivery (telephonic, video, etc.) to determine needed improvements to telecommunication equipment for 24 hour a day 7 day a week consultation.

Appropriate legal and clinical expertise will be utilized to develop necessary agreements for sharing of patient information. In addition, participating primary care physicians and area hospital will be requested to complete screenings for depression substance use disorder as a means to identify individuals who would benefit from early treatment. The screening tools to be utilized include the PHQ-9 (depression screening for adults), the PHQ-A/BDI-PC (depression screenings for adolescents, and the CAGE/AUDIT (screening tools for substance use disorder). The screenings would be performed at the primary care physician's office or local hospital and the number of individuals receiving each assessment would be reported to Hill Country. All consultative services will be recorded in Hill Country's electronic database (Anasazi) within units and subunits that will keep track of the number of services performed and the location of the services.

Challenges or Issues Faced by the Performing Provider
The greatest challenge of the project will be recruitment of necessary personnel. Hill Country will address the challenge by offering incentives as necessary.

Project Goals
The goal of this project is to provide PCPs and hospitals within Hays County with the necessary resources and guidance to adequately treat patients, who present with behavioral health conditions, through Psychiatric Consultation.

5-Year Expected Outcome for Provider and Patients:
By the end of five years, Hill Country MHDD Centers will have an established psychiatric consultation service available for all primary care providers and hospitals within Hays County with at least twenty-five providers enrolled and a minimum of twenty percent of primary care physicians within the counties utilizing the service will be satisfied with the psychiatric consultation provided for patients in their care. Overall, the availability of Psychiatric Consultation should result in earlier identification and treatment of mental health issues and increase integration of services for individuals seeking psychiatric assistance in the primary care setting. To demonstrate the progress of identifying behavioral health issues, Hill Country anticipates that 5% of the respective populations will have the following assessments completed:

- PHQ-A/BDI-PC for identifying depression in adolescents
- PHQ-9 for identifying depression in adults and
- CAGE/AUDIT for identifying substance use disorder in adults.

How the Project is Related to RHP Goals
The goal of this project is to establish Virtual Psychiatric and Clinical Guidance to Primary Care Physicians and Hospitals. By providing Virtual Psychiatric and Clinical Guidance in the community, Hill Country will be meeting the regional goals of:

- 3 Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems; and
- 6 Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.

Starting Point/Baseline

Baseline Data
There are currently no dedicated resources for behavioral health consultation available to hospitals and primary care physicians within Hays County. No formal structure currently exists for primary care physicians and hospitals to obtain clinical guidance regarding patients presenting with behavioral health issues.

Reason for Selection of Project Options and Components
As a formal structure for psychiatric consultation for primary care physicians and hospitals does not exist within Hays County, Hill Country MHDD Centers proposes to meet all required project components:

A) *Establish the infrastructure and clinical expertise to provide remote psychiatric consultative services.* Hill Country will review and improve telecommunication equipment based on estimated volume of services and recruit appropriate clinical staff with the clinical expertise to provide remote psychiatric consultative services.
B) *Determine the location of primary care settings with a high number of individuals with behavioral health disorders (mental health and substance abuse) presenting for services, and where ready access to behavioral health expertise is*

lacking. Identify what expertise primary care providers lack and what they identify as their greatest needs for psychiatric and/or substance abuse treatment consultation via survey or other means. Hill Country will survey area hospitals and primary care physicians to determine the potential volume of consultation needed as well as the primary types of issues where consultation is needed. The survey will include areas of needed consultation, estimated of occurrences for consultation, as well as the means by which the primary care physician wishes to receive consultation.

C) *Assess applicable models for deployment of virtual psychiatric consultative and clinical guidance models* Based on feedback from primary care physicians and hospitals, Hill Country will review successful models of psychiatric consultation and assess the models for applicability to the region being served to determine the most appropriate methods to implement.

D) *Build the infrastructure needed to connect providers to virtual behavioral health consultation.* Hill Country will review current telecommunication capacity and improve telecommunication and telemedicine equipment based on estimated volume of services and connections needed to perform consultation efficiently and effectively based on the volume of services estimated and the model of consultation being provided. Hill Country will also develop staffing patterns and acquire all necessary personnel to ensure appropriate clinical expertise is available for consultation regarding both adult and children's mental health needs.

E) Ensuring staff administering virtual psychiatric consultative services are available to field communication from medical staff on a 24-hour basis. Hill Country will staff the program for 24 hour a day coverage, will survey hospitals and primary care physicians to ensure clinical guidance is available 24 hours a day as needed, and conduct random mystery calls for clinical guidance to ensure 24 hour virtual psychiatric consultative services are available.

F) *Identify which medical disciplines within primary care settings (nursing, nursing assistants, pharmacists, primary care physicians, etc.) could benefit from remote psychiatric consultation.* Based on the recommended model of implementation for the service area and feedback from primary care physicians, area hospitals and other medical providers, Hill Country will conduct needs assessments to determine which primary care settings could benefit from remote psychiatric consultation.

G) *Provide outreach to medical disciplines in primary care settings that are in need of telephonic behavioral health expertise and communicate a clear protocol on how to access these services.* Based on needs assessments and survey, Hill Country will develop protocol and enter memorandums of understanding which define a clear protocol on how to access the remote psychiatric consultation.

H) *Identify clinical code modifiers and/or modify electronic health record data systems to allow for documenting the use of telephonic behavioral health consultation.* Hill Country will add necessary service codes and modifiers to the EHR and other tracking documents within the agency to track all activity of the telephonic behavioral health consultation.

I) *Develop and implement data collection and reporting standards for remotely delivered behavioral health consultative services.* Hill Country will formalize procedures for collecting and reporting on activities associated with remotely delivered behavioral health consultative services.

J) *Review the intervention(s) impact on access to telephonic psychiatric consults 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* Hill Country will continually review with primary care providers how the service has supported their practice, ways to improve the service, and how to expand the service to additional providers.

Reason for Selection of Milestones and Metrics

In selection of milestones for the project, all milestones selected were the measures that would ensure success of the project. Detailed planning and consideration of lessons learned from other programs are

essential during DY2. The DY3 milestone concentrates on number of providers enrolled and establishing tracking of services in order to ensure the project is operational during DY3. DY4 and DY5 have primary care physician satisfaction and continuous evaluation and improvement of the program. These milestones are essential to evaluate the ongoing quality and success of the program and to make any necessary adjustments to improve the program in the future.

Unique Community Need Identification Number

CN.4 Inadequate access to behavioral health care

CN.6 Inadequate services throughout the continuum of care for individuals with behavioral health issues such as: prevention and supported recovery; screening, outpatient treatment, and integrated care; intensive outpatient, supported housing, and residential treatment; crisis stabilization services, detoxification services, and medical/psychiatric, and inpatient care.

CN.7 Lack of coordination of care across: settings of care; multiple conditions; physical and behavioral health.

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

There are currently no Virtual Psychiatric Consultation services available within Hays County served by Hill Country in RHP7.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

This project is not related to any U.S. Dept. of Health and Human Services funded initiative.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

OD-12 Primary Care and Primary Prevention

IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)

The number of PHQ-A/BDI-PC performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the 12 to 18 year population of Hays County as determined by Texas Department of State Health Services population estimates.

IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)

The number of PHQ-9 performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Hays County as determined by Texas Department of State Health Services population estimates.

IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

The number of CAGE/AUDIT performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Hays County as determined by Texas Department of State Health Services population estimates

Reasons/Rationale for Selecting the Outcome Measure(s)

The screening instruments were selected as a method for primary care providers to identify issues that may require virtual psychiatric consultation. By performing the instruments, early diagnosis and intervention of potential symptoms may be addressed in order to avoid escalation of symptoms into a crisis episode.

How Project Supports, Reinforces, Enables Other Projects

Provision of Hays County Psychiatric Consultation as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 7 (133340307.1.1 Hays County Mobile Clinic, 133340307.2.1 Hays County Mental Health Center Integrated Care, 133340307.2.2 IDD Mental Health Crisis Center, 133340307.2.3 Co-occurring Psychiatric and Substance Use Disorder Services and 1333040307.4 Trauma Informed Care, 133340307.2.5 Veteran's Mental Health, 133340307.2.6 Children's Mental Health Crisis Respite Center, 133340307.2.7 Children's Mental Health Trauma Services, 13340307.2.8 Mental Health Court, 133340307.2.9 Whole Health Peer Support, 133340307.2.10 Adolescent Whole Health Peer Support, and 133340307.2.11 Family Partner) by providing specialized services addressing the impact of trauma for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms is reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions.

Relationship to Other Performing Providers' Projects in the RHP

Hill Country MHDD Centers is the local mental health authority that provides services within Hays County of Regional Healthcare Partnership 7: The other two local mental health authorities (Austin Travis County Integral Care and Bluebonnet Trails) provides mental health services to the remaining counties within Regional Healthcare Partnership 7 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in a learning collaborative with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Related projects include:

133542405.1.3 - Austin Travis County Integral Care - Introduce, Expand, or Enhance Telemedicine/Telehealth
307459301.1.8 - Community Care Collaborative - Telepsychiatry in Federally Qualified Primary Health Clinics
137265806.1.1 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Emergency Department
137265806.1.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Psychiatric Telemedicine for Emergency Services
137265806.2.3 - Seton Healthcare Family: University Medical Center at Brackenridge - Substance Abuse Disorder Navigation
137265806.2.4 - Seton Healthcare Family: University Medical Center at Brackenridge - Behavioral Health Assessment and Resource Navigation

Plan for Learning Collaborative

Hill Country MHDD Centers will participate in a learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects

Project Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

The valuation on this project is based on an estimated 2000 individuals receiving psychiatric clinical consultation services for individual patients over the life of the project.

133340307.2.12	*2.16*	*2.16.1A-J*	Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hays County Virtual Psychiatric and Clinical Guidance	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.13* *133340307.3.14* *133340307.3.15*	*3.IT-12.5* *3.IT-12.5* *3.IT-12.5*	Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) Other USPSTF-endorsed screening outcome measures (PHQ-9) Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-2: Design psychiatric consultation services that would allow medical professionals in primary care settings to access professional behavioral health expertise (via methods such as telephone, instant messaging, video conference, facsimile, and email) Metric 1 P-2.1: Establish project plans which are based on evidence/experience and which address the project goals Baseline: No intervention has been designed Goal: Submission of project plan Data Source: Project documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $606,504	**Milestone 2** P-3: Enroll primary care settings into the remote behavioral health consultation services Metric 1 P-3.1: Number of PCP settings that use psychiatric consultative services Baseline: 0 providers enrolled Goal: Enroll 15 providers Data Source: Signed enrollment agreements Milestone 2 Estimated Incentive Payment: $ 312,315 **Milestone 3** P-4: Determine the impact of the project Metric 1 P-4.1: Develop evaluation plan including metrics, operation and evaluation protocols Baseline: No intervention has been designed Goal: Develop formal plan for Quality and Utilization Management of project including development of clinical code modifiers and data collection as well as satisfaction of physicians receiving		**Milestone 4** P-3: Enroll primary care settings into the remote behavioral health consultation services Metric 1 P-3.1: Number of PCP settings that use psychiatric consultative services Baseline: 0 providers enrolled Goal: Have cumulative of 50 providers enrolled Data Source: Signed enrollment agreements Milestone 4 Estimated Incentive Payment: 210,038 **Milestone 5** P-5: Evaluate and continuously improve psychiatric consultative services Metric 1 P-5.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Baseline: No intervention has been designed Goal: Documentation of data analysis and how data was utilized to improve service delivery at least 6 times during	**Milestone 7** P-5: Evaluate and continuously improve psychiatric consultative services Metric 1 P-5.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Baseline: DY 4 Process initiative Goal: Documentation of data analysis and how data was utilized to improve service delivery at least 6 times during the year Data Source: Project reports include documentation of how real-time data was used for rapid-cycle improvement to guide continuous quality improvement Milestone 7 Estimated Incentive Payment: $322,531 **Milestone 8** [I-X]: Number of patients/individuals receiving psychiatric consultation **Metric 1** [I-X.1]: Number of targeted individuals receiving

133340307.2.12	*2.16*	*2.16.1A-J*	Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hays County Virtual Psychiatric and Clinical Guidance	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.13* *133340307.3.14* *133340307.3.15*	*3.IT-12.5* *3.IT-12.5* *3.IT-12.5*	Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) Other USPSTF-endorsed screening outcome measures (PHQ-9) Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	consultation services Data Source: Project documentation including formal plan for Quality and Utilization Management of project including development of clinical code modifiers and data collection as well as satisfaction of physicians receiving consultation services Milestone 3 Estimated Incentive Payment: $ 312,315	the year Data Source: Project reports include documentation of how real-time data was used for rapid-cycle improvement to guide continuous quality improvement Milestone 5 Estimated Incentive Payment: $210,038 **Milestone 6** [I-X]: Number of patients/individuals receiving psychiatric consultation **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals receiving psychiatric consultation **Baseline/Goal**: Baseline - 0 individuals receiving psychiatric consultation; Goal – 750 individuals/patients receiving psychiatric consultation during DY4; **Data Source**: Hill Country	psychiatric consultation **Baseline/Goal**: Baseline - 0 individuals receiving psychiatric consultation; Goal – 1,000 individuals/patients receiving psychiatric consultation during DY5; **Data Source**: Hill Country MHDD records/EHR **Milestone 8 Estimated Incentive Payment: $322,531**

133340307.2.12	***2.16***	***2.16.1A-J***	Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hays County Virtual Psychiatric and Clinical Guidance	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)				*133340307*
Related Category 3 Outcome Measure(s):	*133340307.3.13* *133340307.3.14* *133340307.3.15*	*3.IT-12.5* *3.IT-12.5* *3.IT-12.5*	Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) Other USPSTF-endorsed screening outcome measures (PHQ-9) Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $210,038**	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $606,504	Year 3 Estimated Milestone Bundle Amount: $624,630		Year 4 Estimated Milestone Bundle Amount: $630,114	Year 5 Estimated Milestone Bundle Amount: $645,062
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,506,310				

University Medical Center at Brackenridge (UMCB)
Category 2 DSRIP Projects

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
OB Navigation
PROJECT ID: 137265806.2.1 PASS 1

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): The project would improve access to pre- and post-natal care for uninsured Hispanic women with limited English proficiency through comprehensive, effective patient navigation services.

Need for the Project: Local data demonstrates the need to develop a navigation team specifically targeted to recent immigrant Hispanic OB patients and increasing their early access into care (CN.12). In 2010 7,476 (47.3%) of the 15,792 births in Travis County were to Hispanic women and only 51.9% received prenatal care in the first trimester.

Target Population: The target population is Hispanic women, with an outreach emphasis on recent immigrants. 100% of the women served by the OB Navigation project will be indigent/uninsured patients at or below 200% of the federal poverty level making them eligible for Medicaid for Pregnant Women or CHIP Perinate. One of the services provided by the Navigators will be to ensure these women are enrolled in coverage.

Category 1 or 2 Expected Patient Benefits:
This is a new project; baseline in zero. The program will serve 200 women in DY3, 400 in DY4 and 600 in DY5. Enrollments will increase by 200 in DY4 and by another 200 in DY5; cumulative program enrollment will be 600 (DY3 through DY5). Please note that we expect a portion of program enrollees to leave the program and return in a subsequent year due to another pregnancy; a re-enrollment will be counted as a new enrollment.

Category 3 Outcomes:

- IT-8.1 – *Rate 1*: The project goal is to increase the percentage of deliveries of program enrollees that received a prenatal care visit in the first trimester or within 42 days of enrollment in program by 3% above baseline (TBD in DY3) in DY4 and by 5% DY5.
- IT-8.1 – *Rate 2:* The project goal is to Increase the percentage of deliveries of program enrollees that had a postpartum visit on or between 21 and 56 days after delivery by 3% above baseline (TBD in DY3) in DY4 and 5% in DY5.
- IT-8.9 - Increase over baseline (TBD in DY3) by 3% in DY4 and 5% ind DY5 the percentage of program enrollees with gestational diabetes metillus (GDM) receiving diabetes testing prior to 13 weeks post-partum

Project Title: OB Navigation

Project Option 2.9.1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

RHP Project Identification Number: 137265806.2.1 Pass 1

Performing Provider Name: University Medical Center Brackenridge (UMC Brackenridge)

TPI: 137265806

Project Description:

UMC Brackenridge proposes to provide navigation services to targeted obstetrics patients who are at high risk of disconnect from institutionalized health care.

The project would improve access to pre- and post-natal care for uninsured Hispanic women with limited English proficiency through comprehensive, effective patient navigation services. Women testing positive for gestational diabetes will receive extra navigation services ensuring they attend prenatal classes focused on managing their diabetes and they receive a postpartum diabetes screen. The Obsterics (Ob) Navigation Program will use culturally and linguistically competent Community Health Workers to serve as Patient Navigators. Patient Navigators will be responsible for navigating vulnerable and high risk mothers through the healthcare system throughout their pregnancy and postpartum period, including subsequent primary care for mom and baby in a medical home. The Navigators will work with two Federally Qualified Health Centers, CommUnity Care and Lone Star Circle of Care, and the Seton Family of Hospitals.

The Ob Navigator team will enroll 10 newly pregnant uninsured Hispanic patients a month in Navigation Services with a goal of enrolling a total of 600 patients by the end of DY5. In 2010, 7,476 (47.3%) of the 15,792 births in Travis County were to Hispanic women and only 51.9% received prenatal care in the first trimester.

To avoid delays in obtaining care early in pregnancy, this project will engage women at the point when they first discover they are pregnant. Patient navigators will develop outreach relationships with agencies and organizations that do not provide prenatal care but are places women are most likely to go for pregnancy testing and or get information about pregnancy services (Neighborhood Centers, WIC, Early Childhood Intervention programs, school nurses, and faith institutions). Navigators will establish a referral process with these agencies and be on-site at various times to meet with pregnant women and enroll them into Navigation services.

Patient Navigators will provide the following services to their patients: (1)schedule and facilitate the initial obstetrics appointment to ensure prenatal treatment and continued care; (2) assist in CHIP Perinate or Medicaid enrollment; (3) educate and assist with enrolling in culturally and linguistically appropriate prenatal classes and pregnancy programs offered by local social service agencies; (4) assist in delivery preregistration and schedule hospital tours; (5) educate patient on the importance of choosing a pediatrician prior to delivery; (6) assist with applying for Emergency Medicaid if

needed; (7) ensure that babies are enrolled in Medicaid, connected to a medical home and have received the required well-checks during their first three months of life; and (8) ensure patients receive a post-partum visit, and have a medical home for future primary care visits. Patients identified with gestational diabetes will receive additional navigation services; enrollment in pregnancy classes on managing their gestational diabetes, ensuring they are re-tested for diabetes postpartum, and educating them on the importance of annual screenings if necessary.

Once recruited, patients will receive follow-up phone calls, communication, education, and support from Navigators to ensure that patients continue prenatal care, delivery, and postpartum follow-ups. Navigation efforts will be aimed at increasing the timeliness of prenatal and postnatal care, and improved birth outcomes such as increased gestational age and birth weight. Specific improvement targets are described in the metrics table. Navigators will use an ACCESS database to document patient encounters and the NextGen and Compass EMR will be used to collect outcome data.

Goals and Relationship to Regional Goals:
The goal of this project is to use community health workers as patient navigators to provide enhanced care coordination, community outreach, social support, and culturally competent care to vulnerable obstetrics patients. For indigent and uninsured Hispanic women with limited English proficiency, access to pre- and post-natal care can be hindered by a lack of knowledge regarding available community resources and a fragmented maze of doctors' offices, clinics, and hospitals. Patient navigators will help and support these patients to navigate through the continuum of health care services throughout their pregnancy. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services.

Project Goals:

1. Increase the number of patients enrolled in prenatal care in the first trimester.
2. Increase the percentage of deliveries that have a postpartum visit on or between 21 and 56 days after delivery.
3. Testing for postnatal gestational diabetes mellitus.

This project meets the following regional goals:

1. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting (RHP goal #2)
2. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across the system (RHP goal #3)
3. Bolster individual and population health by improving chronic disease management (RHP goal #4)

The Ob Navigation program uses a patient-centered, coordinated care navigation model that aims to improve perinatal outcomes, improve satisfaction through timely access to appropriate care, and builds on the existing provider network. The program leverages the existing Travis County prenatal care infrastructure to meet the need for increased enrollment in early prenatal care with the goal of improving the perinatal outcomes of patients receiving navigation services.

Challenges:

The primary challenges for this project include providing services to pregnant women who may be transient and fearful of accessing services. Building trust and engaging frequently with patients will be key in the success of the project. The project will hire culturally and linguistically competent Navigators, ensuring they receive proper training and have access and support from clinic and hospital based clinicians and administrators to resolve barriers patients encounter. Because of the mobile nature of this population, staying in touch with patients with gestational diabetes may be challenging. To address this possibility, the program will provide information about the benefits of postnatal getstational diabetes and easy access to free postnatal testing prior to delivery.

5-Year Expected Outcome for Provider and Patients:
The program expects to see improvements in the perinatal outcomes for 600 patients enrolled in navigation services and delivering at UMC Brackenridge or other Seton Hospital, as well as, improvements in early access to pre- and post-natal care. This increase access to care is expected to result in better health outcomes for mothers and their babies and reduce costs related to avoidable complications and pregnancy-related illnesses.

Starting Point/Baseline:
Currently UMC Brackenridge has an obstetrics navigation program for women that have already established care with a provider, focusing on assisting CHIP Perinate patients with applying for Emergency Medicaid, pre-registering patients for delivery, and scheduling hospital tours. This project targets women who have not approached a provider about prenatal care or registered for delivery. Interventions targeting patients prior to accessing care and increasing early pre- and post-natal care do not exist; therefore the baseline for number of participants begins at 0 in DY2. The program will be developed in DY2 and will include training two navigators. Enrollment of 200 indiviudals is expected by end of DY3.

Rationale:
Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, payment systems, support organizations and other components of the healthcare system. Services provided by Ob patient navigators will include:

- o Coordinating care among providers.
- o Arranging financial support and assisting with paperwork.
- o Assisting with transportation arrangements.
- o Facilitating follow-up appointments.
- o Community outreach and building partnership with local agencies and groups.

Patient Navigators will have close ties to the local community and serve as important links between underserved communities and the healthcare system. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities. Patient navigators will be:

- o Compassionate, sensitive, and culturally attuned to the people and community
- o Knowledgeable about the environment and healthcare system
- o Connected with critical decision makers inside the system

Local data demonstrates the need to develop a navigation team specifically targeted to recent immigrant Hispanic Ob patients and increasing their early access into care. The need for this project is based on data in the section Maternal and Child Health, of the *RHP #7 Community Needs Assessment, Full Report, July 2012,* which details 2010 Texas Department of State Health Services vital statistics report on the percent of women receiving prenatal care in the first trimester (http://www.dshs.state.tx.us/chs/vstat/vs10/t12.shtm). These DSHS reports evidence that during the first trimester of pregnancy, 58.4% of all pregnant women in Texas accessed prenatal care in the first trimester of pregnancy, and 59.7% of all Travis County pregnant women did as well. However, only 55.5% of all pregnant Hispanic women in Texas received prenatal care in their first trimester compared to 69.9% of pregnant white women. The disparity in care is brought down to the local level with data showing that 51.9% of 7,476 births to pregnant Hispanic women in Travis County accessed prenatal care in their first trimester compared to 82.8% of white women.

Project Components:
Through the Ob Navigation Program, we propose to meet all required project components.

a) *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* Pregnant patients seen in the emergency department will be referred to the patient navigators by ED staff and or through discharge reports. Navigators will contact these patients and enroll them in Navigation services and assist them with finding a prenatal care home if they don't have one. All of our navigators will attend the Community Health Worker Training and Certification program established by the Department of State Health Services.

b) *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* We plan to hire Patient Navigators with a background in community health, social services, mental health, or public health. These individuals will be bilingual, from our community, and experienced in identifying community resources.

c) *Connect patients to primary and preventive care.* A focus of this project is to not only connect pregnant patients to obstetrics care for timely prenatal and post-partum care, but ensure both mom and baby have a medical home post-delivery.

d) Increase access to care management and/or chronic care management including education in chronic disease self-management. This project will work with both the clinic and hospital staff to create culturally and linguistically competent prenatal education classes and ensure they are taught in locations and at times most convenient for patients. Patients with GDM will also be enrolled in a series of classes specific to managing their diabetes.

e) *Conduct quality improvement for project using methods such as rapid cycle improvement-* We implement the Plan-Do-Study-Act to test different aspects of the Navigation program. Regular reports will be pulled from the Navigator enrollment database to assess the length of time between patients being enrolled in Navigation services and their first prenatal appointment, the gestational age of patients at enrollment, to ensure early access to prenatal care is being accomplished. Reports will be pulled to assess the effectiveness of outreach sites. Regular analysis of referral/enrollment locations will be completed to ensure Navigators are

spending their time in locations shown to have a high number of successful referrals/ program enrollments.

Unique community need identification numbers the project addresses:
CN.2- Inadequate access to specialty care
CN.9 – High rates of chronic disease, e.g. rising rates of diabetes
CN.12- Lack of adequate prenatal care
CN.16-Lack of services for special populations such as children
CN.17- Increasing diversity of the regions, exacerbating the existing racial and ethnic disparities across many health conditions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative.
The new Ob Navigation project, unlike the existing Navigation program that serves women receiving prenatal care, this will focus on outreaching to patients prior to their being in prenatal care and will follow the patients for two months post-partum ensuring they have access to prenatal care as early as possible and have a post-partum visit between 21 and 56 days after delivery. The Navigators involved in this project will make more frequent contacts with patients and will connect patients to a primary care medical home before ending their relationship with the patient.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives. UMCB participates in the *Medicare and Medicaid Electronic Health Records Incentive Program* for hospitals; extension of this program to UMCB-affiliated physician offices and clinics is in development; participation in the EHR program is expected to support the care delivered under this project and coordination between providers.

Performing provider has ensured that all project plans are based upon community needs and operate in connungtion with the RHP-wide initiatves. Furthermore, this proposed orject meets the needs of the specific population and will not duplicate services of other perofmring provider projects in the RHP.

<u>Related Category 3 Outcome Measures:</u>

OD-8 Perinatal Outcomes:

- IT-8.1 Timeliness of Prenatal/Postnatal Care
- IT-8.9 Other Outcome Improvement Target

Reasons/rationale for selecting the outcome measures:
Perinatal outcomes data relating to selected Category 3 outcomes are described above and all are identified as Healthy People 2020 objectives by the federal government. Ob navigators will

assist low-income women to secure insurance and/or enter prenatal care timely. According to the Institute of Medicine, prenatal care and specifically, entry into prenatal care in the first trimester, has a positive effect on perinatal outcomes, such as low birth-weight.[lxxxvii] Moreover, entry into prenatal care and subsequent post-partum care provide significant opportunities to treat co-morbid conditions, such as gestational diabetes mellitus, to introduce mothers to health education, and to promote wellness through an encounter with a medical home. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6–12 weeks postpartum and managed appropriately.

Relationship to other Projects:
UMCB will also implement a women's cancer care navigation program that will use a similar intervention strategy: 137265806.2.8.

137265806.1.4 – Language Services Resources Center
137265806.1.6 – Cultural Competency Care Training

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-3: Potentially Preventable Complications
RD-4: Patient Satisfaction

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
The Obstetrics Care Navigation Program will focus on uninsured Hispanic women with limited English proficiency while another DSRIP project in RHP #7 (201320302.2.4 - City of Austin Health & Human Services Department - Prenatal & Postnatal Improvement Program) will focus on reducing disparities for pregnant African American Women. These programs will work closely together and will communicate often. Warm-hand-offs of patients will be made connecting patients to the appropriate Navigation program. No uninsured pregnant woman, within the target population to be served, will be turned away from receiving Navigation services.

The Provider will fully participate in RHP-wide learning collaboratives for projects that directly address increasing access to prenatal care and all projects providing navigation services to patients. Regular sharing between providers with similar projects and/ or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically. Other related projects include:
176692501.1.1 - St. Mark's Medical Center - Expanding Access to Specialty Care
201320302.2.5 - City of Austin Health & Human Services Department - Healthy Families Program Expansion
307459301.1.4 - Community Care Collaborative - Expansion of Dental Services
307459301.2.6 - Community Care Collaborative - Community Paramedic Patient Navigation Program

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time,

and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

This project presents a significant opportunity to increase the number of Hispanic women receiving early prenatal care and postpartum care, and ensure their babies have a medical home. This project will navigate 600 pregnant women and their babies over the course of the Waiver demonstration period.

[1] Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes; Behrman RE, Butler AS, editors. *Preterm Birth: Causes, Consequences, and Prevention.* Washing ton (DC): National Academies Press (US); 2007

UNIQUE IDENTIFIER: 137265806.2.1	***RHP PP REFERENCE NUMBER:*** 2.9.1	***PROJECT COMPONENTS***: 2.9.1 (a-e)	***PROJECT TITLE:*** Obstetrics Care Navigation Provide Navigation Services to targeted patients who are at high risk of disconnect from intuitional care.	
Performing Provider: University Medical Center Brackenridge				**TPI:** 137265806
Related Cat 3 Outcome Measure:	137265806.3.1	IT-8.1 8.9	Timeliness of Prenatal/Postnatal Care Other Outcome Improvement Target	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-2]: Establish/expand a healthcare navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education Metric 1 [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline: At beginning of DY2, Patient Navigators did not exist; therefore baseline is 0. Goal: Develop training program with procedures and continuing education plan. Train and deploy a team of 2 navigators. Data Source: Human Resources and Training Documentation. Milestone 1 Estimated Incentive Payment: $96,694	Milestone 3 [I-X]: Provide navigation services to targeted patients. Metric 1 [I-X.1]: Increase in the number of targeted patients enrolled in the Patient Navigation Program. Baseline: At beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Goal: Enroll 200 patients into the program.Program enrollment 200. Data Source: Enrollment reports Milestone 3 Estimated Incentive Payment: $232,217 Milestone 4 [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP.		Milestone 5 [I-X]: Provide navigation services to targeted patients. Metric 1 [I-X.1]: Increase in the number of patients enrolled in the Patient Navigation Program. Baseline: At beginning of DY2, baseline was 0. Goal: Enroll additional 200 patients into the program in DY4Cumulative program enrollment 400. Data Source: Enrollment reports Milestone 5: Estimated Incentive Payment: $215,651 Milestone 6 [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	Milestone 7 [I-X]: Provide navigation services to targeted patients. Metric 8 [I-X.1]: Increase in the number of patients enrolled in the Patient Navigation Program. Baseline: At beginning of DY2, baseline was 0. Goal: Enroll additional 200 patients into the program DY5 Cumulative program enrollment 600. Data Source: Enrollment reports Milestone 7 Estimated Incentive Payment: $163,895 Milestone 8 [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

UNIQUE IDENTIFIER: 137265806.2.1	***RHP PP REFERENCE NUMBER:*** 2.9.1	***PROJECT COMPONENTS***: 2.9.1 (a-e)	***PROJECT TITLE:*** Obstetrics Care Navigation Provide Navigation Services to targeted patients who are at high risk of disconnect from intuitional care.	
Performing Provider: University Medical Center Brackenridge				**TPI:** 137265806
Related Cat 3 Outcome Measure:	137265806.3.1	IT-8.1 8.9	Timeliness of Prenatal/Postnatal Care Other Outcome Improvement Target	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared and similar projects. Metric 1 [P.8-1:] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 2 Estimated Incentive Payment: $96,695	Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 4 Estimated Incentive Payment: $232,217		Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 6: Estimated Incentive Payment: $215,652	Baseline/Goal: Participate in face-to-face learnings at least twice a year. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 8 Estimated Incentive Payment: $163,895
Year 2 Estimated Milestone Bundle Amount: $193,389	Year 3 Estimated Milestone Bundle Amount: $464,434		Year 4 Estimated Milestone Bundle Amount: $431,303	Year 5 Estimated Milestone Bundle Amount: $327,790
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,416,916				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Women's Oncology Care Screening
PROJECT ID: 137265806.2.2 – PASS 2

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project expands timely access to breast and cervical cancer screening via a mobile unit for uninsured and underinsured women in Travis County, who, without this expansion likely would not receive these life-saving services.

Need for the Project: Cancer is the leading cause of death in Travis County and the second leading cause of death in Region 7. This project meets community need CN.9 to address high rates of cancer.

Target Population: The target population is primarily indigent persons who are unable to access these services through traditional modalities due to transportation, work schedules, child-care, lack of insurance or other funding, and other community barriers. This project targets uninsured and underinsured women ages 40-64 in Travis County needing breast cancer and/or cervical screening for women ages 21-64. This project excludes women already enrolled in the county medical assistance program (MAP) or Medicaid because these two programs provide such screenings to their participants.

***C*ategory 1 or 2 Expected Patient Benefits:** This project will increase the number of breast and cervical cancer screenings for indigent/uninsured women as follows:

Number of Screenings	DY2	DY3	DY4	DY5	Total
Breast Cancer Screens	1650	2,000	2,124	2,250	8,024
Cervical Cancer Screens	0	450	1,000	1,500	2,950

Screening services for abnormal results will be navigated to a definitive diagnosis cumulative (DY2-DY5) this project will provide 10,974 screenings.

Category 3 Outcomes: IT-12.6-Other Outcome Improvement Target:

- *Rate 1*- The percentage of program participants with abnormal mammography screening results who followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient setting within 45 days will increase by 3% in DY4 and by 5% in DY5.
- *Rate 2* – Initial Management of abnormal cervical cytology (pap test) and HPV test in adult females (006314). Increase number of women age 21 years and older with a high-grade squamous intraepithelial lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months by 3% in DY4 and 5% by DY5.

Title of Project: **Women's Oncology Care Screening**

Category / Project Area / Project Option: **2.7.1**

RHP Project Identification Number: **137265806.2.2 – Pass 2**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description:
This project expands access to timely breast and cervical cancer screening and, as indicated, to diagnostic resolution, for indigent/uninsured women in Travis County, who, without this expansion likely would not receive these life-saving services.

This project will expand access to breast cancer screenings for unfunded and uninsured women in Travis county between the ages of 40 and 64 via Seton's digital mammography mobile unit known as the *Big Pink Bus* http://thebigpinkbus.com/. Access to cervical cancer screenings will also be expanded to mobile mammography program participants by utilizing advanced practice nurses on the mobile unit or at our community clinics that provide indigent care. Women enrolled in the county's medical assistance program or Medicaid with access to such screenings and are excluded from the project's target population.

Patient navigation services will be provided for women with abnormal screening results to provide timely, definitive diagnosis, or those with cancer, to a treatment provider. Based on our experience serving enrollees of the county medical assistance program (MAP), we anticipate that thirteen percent (13%) of women screened for breast cancer will have an abnormal finding and need to be navigated to diagnosis, with ten percent (10%) of those women diagnosed with breast cancer. Navigation services include referrals to low or no-cost diagnostics, assistance with transportation, arranging financial support and assistance with paperwork, facilitating follow-up appointments, and community outreach and education.

Mobile screening locations will be determined in collaboration with community organizations who also serve low-income women. The relationships established between these community partners and their own clients, members, and parishioners will be utilized to identify and target populations and refer women for services.

Goals and Relationship to Regional Goals:
The objective of this project is to reduce the incidence of and/or death from cancer by detecting early stage disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur.

Project Goals:
In furtherance of the objective, the project has the following goals:

1) Expand access for indigent/uninsured women to breast cancer screening by providing free mammography screens.
2) Expand access for indigent/uninsured women to free cervical cancer screens.
3) Provide culturally competent breast and cervical cancer health education.
4) Ensure women with abnormal screening results are navigated to definitive diagnosis in a timely manner.
5) Reduce costs and improve patient outcomes by identifying cancers in early stages and reduce or prevent cancer treatment costs.

This project meets the following regional goals:

- Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. (Goal #1)
- Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. (Goal #2)
- Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. (Goal #3)
- Support prevention education and healthy lifestyles to improve population health (Goal #5)

Challenges:
Travis County has a culturally and linguistically diverse population. We will address this challenge by providing navigation and screening services in a culturally and linguistically appropriate manner: 1) using existing Seton approved language translation vendors to ensure navigation and screenings services are appropriately communicated to clients; and 2) collaborating with Seton project owners conducting DSRIPS in the area of expanding language translation services and cultural competency training.

5-Year Expected Outcome for Provider and Patients:
By the end of the demonstration (DY5) this project will provide 8,024 breast cancer screenings and 2,950 cervical cancer screenings to indigent/uninsured women. This project will increase the number abnormal mammography screens results will be navigated to a definitive diagnosis.

Starting Point/Baseline:
This project serves a new target population. Enrollment at 9/30/12 (DY1) was zero; therefore baseline is zero. Improvement Milestones will capture each type of screening separately. This project will also ensure timely management of abnormal cervical cytology results for women with a high-grade lesion.

Rationale:
In 2012, it is estimated that 16,000 women in Texas will be diagnosed with breast cancer and another 2,800 will die from the disease. The *Texas Cancer Plan 2012* notes that, "breast cancer is the most common cancer among women in Texas. In 2007, breast cancer in Texas resulted in direct costs of $923.7 million. Locally, cancer is the second leading cause of death in the region and the leading cause of death in Travis County, with 27% of its adult residents ages 18-64 uninsured.[69] In

[69] RHP #7 Community Needs Assessment

Austin, Hispanics and African American's have higher breast cancer incidence and/or mortality rates.[70]

Studies suggest that routine mammography screening can significantly reduce deaths from breast cancer; however, a recent survey showed that 30% of women age 40 and older reported not receiving a mammogram in the last two years."[71] According to the Centers for Disease Control, 72.4% of women follow the recommendations for obtaining mammograms for breast cancer screening.[72] This is below the breast cancer screening target of 81.1% set by *Healthy People 2020* report. Considerably lower mammography use is also reported for those with no usual source of health care (36.2%) or no health insurance (38.2%)."[73] Screening rates are also lower than the average for Hispanics and Asian Americans. [74]

The US Preventive Services Task Force has found that there is high certainty that the net benefit of cervical cancer screening is also substantial.[75] Travis County cervical cancer incidence rates are above the national average. [76] "Of all cancers, cervical cancer is one of the most preventable and detectable through regular screening; however, a recent survey showed that 24% of women age 18 and older reported not having a cervical cancer screening within the past 3 years" and screening rates are declining.[77] "Hispanic women have higher incidence rates of cervical cancer compared with other racial/ethnic groups; black women suffer higher mortality rates for cervical cancer than other racial/ethnic groups."[78]

Navigation from abnormality to definitive diagnosis has been found to save healthcare dollars and benefit time to diagnosis among a racially/ethnically diverse inner city population. [79] [80] Navigators help address fear and lack of breast health education and play a critical role in preventing these women from accessing what, to them, becomes an overwhelming healthcare system. [81]

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[70] Komen for the Cure Austin's 2011 Community Profile

[71] Texas Cancer Plan 2012, http://www.cprit.state.tx.us/images/uploads/tcp2012_web_v2a.pdf

[72] 2010 [National Health Interview Survey]NHIS

[73] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a1.htm

[74] http://www.cdc.gov/cancer/breast/statistics/screening.htm note: the CDC data is based on women age 50-74 that have had a mammogram in the last two years. Compliance with American Cancer Society guidelines of annual mammograms starting at age 40 may be less.

[75] http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm

[76] http://statecancerprofiles.cancer.gov/cgi-bin/quickprofiles/profile.pl?48&057

[77] Texas Cancer Plan 2012, http://www.cprit.state.tx.us/images/uploads/tcp2012_web_v2a.pdf

[78] Texas Cancer Plan 2012, http://www.cprit.state.tx.us/images/uploads/tcp2012_web_v2a.pdf

[79] Williams KP, Mabiso A, Todem D, Hammad A, Hill-Ashford Y, Hamade H, et al. Differences in knowledge of breast cancer screening among African American, Arab American, and Latina women. Prev Chronic Dis 2011;8(1):A20. http://www.cdc.gov/pcd/issues/2011/jan/09_0185.htm. Accessed 11/04/2012.

[80] Cancer Epidemiol Biomarkers Prev. 2012 Oct;21(10):1645-54. doi: 10.1158/1055-9965.EPI-12-0532. Boston patient navigation research program: the impact of navigation on time to diagnostic resolution after abnormal cancer screening. Battaglia TA, Bak SM, Heeren T, Chen CA, Kalish R, Tringale S, Taylor JO, Lottero B, Egan AP, Thakrar N, Freund KM. http://www.ncbi.nlm.nih.gov/pubmed/23045539. Accessed 11-04-2012.

[81] http://www.komenaustin.org/assets/understanding-breast-cancer/2011-executive-summary.pdf

Project Components:
The only required component for this project is quality improvement activities.

Unique community need identification numbers the project addresses:

- CN.9 - High rates of chronic disease such as: cardiovascular disease, cancer and rising rates of diabetes
- CN.17 - Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions
- CN.5 - Transportation access for people in the rural areas and also for low income populations in urban areas

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project significantly expands existing breast and cervical cancer services to a new population of indigent/uninsured women in Travis County.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measures:
IT-12.6 Other Outcome Improvement Target
Rate 1 – Imaging efficiency results (NQMC 006362)
Rate 2 – Initial management of abnormal cervical cytology (NQMC 006314)

Reasons/rationale for selecting the outcome measures:
Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early stage disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur.

Navigation from abnormality to definitive diagnosis has been found to save healthcare dollars and benefit time to diagnosis among a racially/ethnically diverse inner city population. Navigators help address the fear and lack of breast health education that play a critical role in preventing women from accessing what, to them, becomes an overwhelming healthcare system.

Relationship to other Projects:
This project is related to UMCB's Women's Oncology Navigation project and together these projects provide services across the continuum of care for oncology patients. While this project targets women at the screening stage, UMCB's Women's Oncology Navigation project targets women in treatment and post-treatment, therefore the two projects are not duplicative.

Provision of navigation services is linked to multiple other DSRIP initiatives: 1) integration of primary and specialty care/care transitions through communication of screening results to primary care and by linking women with specialty diagnostic and treatment services, 2) standardized navigation pathways and practices promote consistent care delivery models, and 3) enhance culturally competent care – materials are available in multiple languages and screening team members speak Spanish as well as English.

137265806.2.8 – Women's Oncology Care Navigation
137265806.1.4 – Language Services Resource Center
137265806.1.5 – Culturally Competent Care Training

List of Related Category 4 Projects
RD-4: Patient Satisfaction
RD-1 Potentially Preventable Admissions
RD-2 Potentially Preventable Readmissions

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

Projects proposed by other providers across the Region also relate to improved management of chronic conditions, including cancer.

307459301.1.1 – Disease Management Registry
307459301.2.1 – Patient-Centered Medical Home Project
307459301.2.2 – Expand Chronic Care Management Models

In addition, other providers are proposing mobile care projects and may exchange ideas and lessons learned within future regional learning collaboratives.

133340307.1.1 – Hays County Mental Health Center Mobile Clinic
307459301.1.3 – Expand Primary Care via Mobile Health Clinics
133542405.2.2 – Mobile Crisis Outreach Team Expansion

The performing provider will fully participate in a RHP-wide learning collaborative for projects which directly address improving healthcare services to all patients and all projects providing navigation services to patients. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference, or electronically.

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to

support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

A new article in the professional journal of the American Cancer Society found that the savings for navigating underserved women from breast screening abnormality to definitive diagnosis ranges from $510 to $2,080.[82] Reaching indigent women with screening mammography can result in earlier stage at diagnosis. With the exception of in situ cancers, the cost of cancer care continue(s) to increase beyond the initial 6-month period. The incremental costs at 6 months after diagnosis are $14,341, $24,002, and $34,469 for those with local, regional, and distant breast cancers, respectively; a nd these costs increased to $22,343, $41,005, and $117,033 at 24 months.[83]

[82] Cancer. 2012 Mar 5. doi: 10.1002/cncr.27487. [Epub ahead of print]

[83] (Med Care. 2011 Jan; 49(1):89-95. Cost of breast cancer treatment in Medicaid: implications for state programs providing coverage for low-income women. Subramanian S, Trogdon J, Ekwueme DU, Gardner JG, Whitmire JT, Rao C. Source: RTI International, Waltham, MA 0245, USA. ssubramanian@rti.org)

UNIQUE CATEGORY 2 IDENTIFIER: 137265806.2.2 – PASS 2	RHP PP REFERENCE NUMBER: 2.7.1	PROJECT COMPONENTS: NONE	PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCED-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS: WOMEN'S ONCOLOGY CARE SCREENING	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.3 – Pass 2*	*IT 12.6*	*Other Outcome Improvement Target*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-1] Development of innovative evidence-based project for target population. Metric **:** [P-1.1] Document innovational strategy and plan. Goal: Produce a strategic plan for an innovative evidence-based plan to encourage breast and cervical cancer screenings among un- and under-insured women facing barriers to access to care. Data Source: Program documentation; strategic plan. Milestone 1 Estimated Incentive Payment: $376,365 **Milestone 2:** [I-7] Increase access to disease prevention programs using innovative project options. Metric: [I-7.1] Increase the number of encounters as defined by the intervention. Baseline: At the beginning of DY2 this project did not exist, therefore baseline is zero.	**Milestone 4:** [I-7] Increase access to disease prevention programs using innovative project options. Metric: [I-7.2] Increase the number of encounters as defined by the intervention. Baseline: At the beginning of DY2 this project did not exist, therefore baseline is zero. Goal: Provide 2,000 mammography screens. Data Source: Program records; patient registries; Milestone 4 Estimated Incentive Payment: $405,347 **Milestone 5:** [I-7] Increase access to disease prevention programs using innovative project options. Metric: [I-7.2] Increase the number of encounters as defined by the intervention. Baseline: At the beginning of DY2 this project did not exist, therefore baseline is zero.		**Milestone 7:** [I-7] Increase access to disease prevention programs using innovative project options. Metric: [I-7.2] Increase the number of encounters as defined by the intervention. Baseline: At the beginning of DY2 this project did not exist, therefore baseline is zero. Goal: Provide 2,124 mammography screens. Data Source: Program records; patient registries Milestone 7: Estimated Incentive Payment: $405,899 **Milestone 8:** [I-7] Increase access to disease prevention programs using innovative project options. Metric: [I-7.2] Increase the number of encounters as defined by the intervention. Baseline: At the beginning of DY2 this project did not exist, therefore baseline is zero.	**Milestone 10:** [I-7] Increase access to disease prevention programs using innovative project options. Metric: [I-7.2] Increase the number of encounters as defined by the intervention. Baseline: At the beginning of DY2 this project did not exist, therefore baseline is zero. Goal: Provide 2,250 mammography screens. Data Source: Program records; patient registries Milestone 10: Estimated Incentive Payment: $335,540 **Milestone 11:** [I-7] Increase access to disease prevention programs using innovative project options. Metric: [I-7.2] Increase the number of encounters as defined by the intervention. Baseline: At the beginning of DY2 this project did not exist, therefore baseline is zero.

UNIQUE CATEGORY 2 IDENTIFIER: 137265806.2.2 – PASS 2	RHP PP REFERENCE NUMBER: 2.7.1	PROJECT COMPONENTS: NONE	PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCED-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS: WOMEN'S ONCOLOGY CARE SCREENING	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.3 – Pass 2*	*IT 12.6*	*Other Outcome Improvement Target*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Goal: Provide 1,650 mammography screens. Data Source: Program records; patient registries Milestone 2 Estimated Incentive Payment: $376,365 **Milestone 3:** [P-7] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-7.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 3: Estimated Incentive Payment: $376,364	Goal: Provide 450 cervical cancer screens Data Source: Program records; patient registries Milestone Estimated Incentive Payment: $405,347 **Milestone 6:** [P-7] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-7.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6: Estimated Incentive Payment: $405,346		Goal: Provide 1,000 cervical cancer screens Data Source: Program records; patient registries Milestone 8 Estimated Incentive Payment: $405,899 **Milestone 9:** [P-7] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-7.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 9: Estimated Incentive Payment: $405,898	Goal: Provide 1,500 cancer screens Data Source: Program records; patient registries Milestone 11 Estimated Incentive Payment: $335,539 **Milestone 12:** [P-7] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-7.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 12: Estimated Incentive Payment: $335,539

UNIQUE CATEGORY 2 IDENTIFIER: 137265806.2.2 – PASS 2	RHP PP REFERENCE NUMBER: 2.7.1	PROJECT COMPONENTS: NONE	PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCED-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS: WOMEN'S ONCOLOGY CARE SCREENING	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.3 – Pass 2*	*IT 12.6*	*Other Outcome Improvement Target*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Year 2 Estimated Milestone Bundle Amount: $ 1,129,094	**Year 3 Estimated Milestone Bundle Amount: $ 1,216,040**	**Year 3 Estimated Milestone Bundle Amount: $ 1,217,696**	**Year 5 Estimated Milestone Bundle Amount: $ 1,006,618**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $ 4,569,448				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Substance Abuse Navigation
PROJECT ID: 137265806.2.3 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project will provide care transition services for patients who are at risk for a Substance Use Disorder (SUD). The purpose of the program will be to direct individuals toward early intervention and provide access to treatment opportunities and education for the indigent and uninsured.

Need for the project: The readmission rate for patients diagnosed with SUD is at 11.4% at Seton Family of Hospital medical/surgical hospitals. This project will allow medical staff to appropriately address SUDs, reduce unprepared detoxification and result in reduced detoxification-related length of inpatient stay (CN.15).

Target population: The Substance Use Disorder Resource Navigation project will serve UMCB patients (inpatients and ED patients) who have been placed on a detoxification protocol or the physician requests a consultation. The project is expected to serve no less than the same payor mix reflected by UMCB as a whole: 21% Medicaid and 42% indigent.

Category 1 or 2 expected patient benefits: This project will provide 650 free substance abuse disorder screenings in DY2, 750 in DY3, 850 in DY4, and 904 in DY5. The project will provide services to 3,154 patients by the end of DY5 (cumulative total). Following the free assessment, patients will be navigated to services in the community.

Category 3 outcomes: [IT-3.8] Reduce by 3% in DY4 and by 5% in DY5, the baseline 30-day readmission rate for participating UMCB inpatients with a principal or secondary diagnosis of substance abuse disorder and with a complete claims history for the 12-months prior to admission.

Title of Project: **Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Substance abuse navigation**

Category / Project Area / Project Option: **2.17.1**

RHP Project Identification Number: **137265806.2.3 – Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description:

UMCB proposes to develop a care transition program for un- and underinsured patients who are at risk for a Substance Use Disorder. The purpose of the program will be to direct individuals toward early intervention/treatment opportunities and education.

This project provides assessment, care coordination and navigation services for predominately un- and underinsured patients who are receiving care in UMCB's inpatient facility or emergency department (ED) and have been identified as at-risk for a Substance Use Disorder (SUD).

Patients will receive an assessment and consultation from Licensed Chemical Dependency counselors or Licensed Master Social workers trained in SUDs. The program will identify community treatment options, provide education regarding the SUD, identify the risks of medically unassisted detoxification and encourage the patient to seek SUD treatment. Follow-up services to support the patient's access and engagement in the treatment for SUD will also be provided. The navigators in this project will have collaborative relationships with community providers and an expansive knowledge of treatment opportunities within the region. The project is directly affiliated with Seton Mind Institute Behavioral Health Services ("SMIBHS") Intensive Outpatient Programs (Chemical Dependency and Dual Diagnosis), which can, when no alternative community provider is available, provide the outpatient care to indigent individuals and Medicaid recipients.

Goals and Relationship to Regional Goals:

The goal of this project is to identify and provide treatment and educational options to patients at risk for SUD. UMCB anticipates that this effort will ultimately result in fewer hospital admissions and readmissions for patients who seek primary or secondary SUD treatment.

Project Goals:

- Identify patients at risk for developing SUD.
- Increase the number of inpatients and ED patients who receive a SUD screening and assessment.
- Provide information regarding community-based treatment opportunities to address SUD.
- Educate at-risk individuals regarding the illness and the risks of medically unassisted detoxification if the individual returns to a hospital for medical care.
- Provide follow up services to encourage engagement in programs.

- Avoid and/or reduce hospital admissions and ED utilization related to primary or secondary diagnosis of SUD for program participants.
- Reduce 30-day readmission rates of inpatients who are program participants.

This project meets the following regional goals:

- Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. (RHP 7 goal #2)
- Support prevention education and healthy lifestyles to improve population health. (RHP goal #5)
- Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery. (RHP goal #6)
- Improve the patient experience of care by increasing the quality of care and patient safety. (RHP goal #7)

Challenges:

UMCB ED and hospital floor staff will be required to identify potential consultation patients; currently, they are overworked and not necessarily trained to address SUD. This challenge will be addressed through training. Patients' willingness to participate in the consultation is likely to be a challenge, as many individuals with SUDs deny having a problem. We will rely on the expertise of the SUD Navigators to address this issue on a case-by-case basis.

5-Year Expected Outcome for Provider and Patients:

This project is expected to increase the number of at-risk inpatients and ED patients who receive an assessment of substance use disorder by 5,960 patients and provide care services to persons identified with a substance use disorder. This project will also provide navigation services to connect patients to SUD services.

Starting Point/Baseline:

Currently, there are no administrative protocols or clinical guidelines to identify and navigate at-risk patients to avoid hospital admission or re-hospitalization. Therefore, the baseline is zero. Services will begin in DY2 with the delivery of SUD screening and assessments to 650.

Rationale:

The purpose of the program will be to direct individuals toward early intervention and provide access to treatment opportunities and education for the indigent and uninsured. Currently, there is no organized effort to identify and navigate at-risk patients into a transition program. Moreover, the detoxification process (medical process) does not educate the patient as to how to avoid re-hospitalization due to a primary or secondary SUD, nor does the detoxification process connect patients to outpatient providers to support ongoing sobriety. This project will provide both services to patients and support shorter lengths of stay related to patients with SUD at UMCB.

Seton Healthcare Family has identified the readmission rate for patients diagnosed with a primary and secondary diagnoses of SUD at 11.4%.[84] An estimated 6,566 at-risk individuals seek treatment at

[84] This rate represents readmissions for all Seton medical/surgical hospitals from July 2011 to July 2012; not only this provider

UMCB annually. The detoxification process (medical process) does not educate the patient as to how to avoid re-hospitalization due to a primary or secondary SUD, nor does the detoxification process connect patients to outpatient providers to support ongoing sobriety. In many cases, these individuals seek medical treatment while having an unknown primary or secondary SUD. In effect, they have an unidentified co-morbidity. If the individual is unaware of the withdrawal component of SUD, she/he could begin detoxification while in the hospital, leading to longer lengths of stay and increased health risk.

With interventions such as that proposed in this project, the at-risk individuals are more likely to self-disclose SUD in future interactions with the health care system. This allows medical staff to appropriately address SUDs, reducing unprepared detoxification, resulting in reduced detoxification-related length of inpatient stay.

This project will also serve at-risk patients presenting at UMCB's ED by providing a free SUD screening and assessment that will aid in the navigation to community-based SUD treatment programs. ED's are on the front line of treatment for SUD. In a national study, there were 5.1 million drug-related ED visits of which one half were attributed to drug misuse or abuse resulting in average of 402 ED visits per 100,000 population which involved illicit drugs.[85] Including ED patients in this project will reduce costs by providing the assistance patients need to obtain the right care, in the right place, at the right time and divert the patient from a hospital admission.

Further, unmanaged SUDs negatively affect at-risk individuals in many facets of life, including costly physical, mental, social and public health problems, as well as engagement with the legal system. For example, according to the Substance Abuse and Mental Health Services Administration (SAMSHA), "Rates of substance dependence or abuse were associated with current employment status in 2011. A higher percentage of unemployed adults aged 18 or older were classified with dependence or abuse (14.8 percent) than were full-time employed adults (8.4 percent) or part-time employed adults (9.8 percent). About half of the adults aged 18 or older with substance dependence or abuse were employed full time in 2011. Of the 18.9 million adults classified with dependence or abuse, 9.8 million (51.8 percent) were employed full time."[86]

Project Components:
This project will meet all of the required core components as follows:

a) *Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports.* A cross-continuum

[85] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *The DAWN Report: Highlights of the 2011 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits*. Rockville, MD. February 22, 2013. http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm

[86] Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

team comprised of SMIBHS, UMCB, and Seton Family of Hospitals social work department will be created to support the goals of this project.

b) *Conduct an analysis of the key drivers of the 30-day hospital readmissions for behavioral health conditions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR tool) and patient and provider interviews.* The project team will have representation on the SMIBHS Utilization Reduction Taskforce to address 30-day behavioral health readmissions and key drivers.

c) *Identify baseline mental health and substance abuse conditions at high risk for readmission, (examples include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency).* The project team will participate in the SMIBHS Utilization Reduction Taskforce to address and identify baseline SUD conditions at high risk for 30-day readmission and high ED utilization.

d) *Review best practices for improving care transitions from a range of evidence-based or evidence-informed models.* DY2 of this project will involve reviewing best practices for achieving optimal outcomes and improving care transitions.

e) *Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.* The project team will meet weekly with representatives from SMIBHS, UMCB, and Seton Family of Hospital Social Worker to evaluate and improve processes, data, patient outcomes, and program effectiveness.

f) *Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.* The project will pilot care transition interventions for both ED and inpatient populations at-risk.

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.* Provider will be participate in face-to-face learnings 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.

This project option also requires a component to conduct quality improvement for the project. As discussed above, the performing provider will participate in learning collaboratives.

Unique community need identification numbers the project addresses:
CN.4: Inadequate access to behavioral health care
CN.6 - Inadequate services throughout the continuum of care for individuals with behavioral health issues, such as:

- Prevention and supported recovery
- Screening, outpatient treatment, and integrated care
- Intensive outpatient, supported housing, and residential treatment

- Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care

CN.7: Lack of coordination of care across

- Settings of care
- Multiple conditions
- Physical and behavioral health

CN.8: High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

CN.15: Additive and costly impact of co-occurring mental health, substance use, and medical conditions

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

This is a new initiative. Currently, a program does not exist to educate, coordinate care and navigate uninsured and underinsured individuals with SUDs within medical/surgical hospitals.

Related Activities Funded by U.S. Dept. of Health and Human Services.

This project compliments, but does not duplicate other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measures:

OD-3: Potentially Preventable Re-Admissions 30-day Readmission Rates (PPRs)

IT-3.8 Behavioral Health/Substance Abuse 30-day readmission rate

Reasons/rationale for selecting the outcome measures:

Interventions such as assessment of substance use disorder as a community initiative and linking patients with appropriate resources will lead to less hospital admissions and readmissions related to behavioral health.

The goals of the waiver are summarized through the triple aims of:

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care

The readmission rate for patients with SUD is currently very high. A hospital admission that might have been avoided with preemptive intervention is contrary to each of these goals. A readmission is a negative experience for the patient, resulting in missed work and lower quality of life. It increases the per capita costs of care, and does nothing to improve the health of the general population. A reduction in SUD related admissions for participating inpatients will be a clear sign of its effectiveness.

Relationship to other Projects:

There are several projects within University Medical Center at Brackenridge that will supplement and support this project. Although these projects are related, they each provide different access points for interventions related to SUD and behavioral health incidents.

137265806.1.3 - Psychiatric Telemedicine
137265806.1.4 - Psychiatric Emergency Department
137265806.2.3 - Behavioral Health Navigation
137265806.2.4 - Chronic Care Management
137265806.2.6 - Care Transitions

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-1: Behavioral Health and Substance Abuse Admission rate
RD-2: Behavioral Health and Substance Abuse: 30-Day Readmissions
RD-4: Patient Satisfaction

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
Substance abuse and other mental health conditions are a great concern over the entire Region, as they tend to co-occur with other chronic diseases, leading to greater health care costs. Several projects propose interventions that would lead to better identification and navigation of SUD and behavioral health patients. Full integration of these services into the healthcare system will take efforts from many providers with related efforts, goals, and outcomes. Projects proposed by other providers across the Region also plan to expand primary care but within different populations.

126844305.1.3 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Outpatient Substance Addiction Services for Adult and Youth in Bastrop, Caldwell, Fayette and Lee Counties
126844305.2.1 - Transitional Housing Guided by Peer Support
126844305.2.4 - Design, implement, and evaluate project that provides integrated primary and behavioral health care services: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County
133340307.2.3 - Co-occurring Psychiatric and Substance Use Disorder
133340307.2.4 - Trauma Informed Care
133542405.2.2 - Expand Mobile Crisis Outreach Team - crisis intervention
133542405.1.3 - Expanded Access for Psych Services for Homeless Population at ARCH
133542405.2.5 - Health Promotion & Wellness for Chronic Disease in Behavioral Health Populations
201320302.2.1 - Provide ACT Model for Participants of HF PSH
133542405.2.1 - Integrate Primary and Behavioral Health Care Services
133542405.2.2 -Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Mobile Crisis Outreach Team Expansion
133542405.2.5 - Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults
133542405.1.1 - Mental Health First Aid and Suicide Prevention
133340307.2.1 - Hays County Mental Health Center Integrated Care
133340307.2.3 - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder
201320302.2.1 - Provide ACT Model for Participants of HF PSH
307459301.2.1 - Patient-Centered Medical Home Project

307459301.1.1 - Implement/enhance and use chronic disease management registry functionalities
307459301.2.2 - Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions
307459301.1.8 - Telepsychiatry in Federally Qualified Primary Health Clinics
307459301.2.6 - Community Paramedic Patient Navigation Program

The performing provider will fully participate in RHP-wide learning collaboratives for projects that directly address SUD and other behavioral health issues. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically.

Project Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE IDENTIFIER: 137265806.2.3 – PASS 3	RHP PP REFERENCE NUMBER 2.17.1	PROJECT COMPONENTS: 2.17.1 (A-G)	PROJECT TITLE: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS: SUBSTANCE ABUSE NAVIGATION	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI – 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.9 – Pass 3*	*IT-3.8*	*Behavioral Health/ Substance Abuse 30-day Readmission Rate*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Establish Task Force or Team to support or lead project. Metric [P-1.1]: Establishment of Task Force or Team. Baseline: N/A Goal: Gather stakeholders for monthly meeting. Data Source: Meeting minutes. Milestone 1 Estimated Incentive Payment: $ 460,710 **Milestone 2:** [P-7]: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines. Metric [P-7.1]: Development of operations manual. Baseline: N/A Goal: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines. Data Source: Program administrative documents	**Milestone 4** [P-4]: Hire clinician (s) with care transition/disease management expertise. Metric [P-4.1]: Position offer letter. Baseline: This is a new project baseline in DY3, for staff is 0. Goal: Hire one lead staff member. Data Source: HR documentation. Milestone 4 Estimated Incentive Payment: $ 372,140 **Milestone 5** [P-3]: Identify baseline high-risk patients analyzing data regarding 30-day readmissions for acute care patients. Metric [P-3.1]: Documentation of chart review. Goal: Produce report analyzing data. Data Source:Program Administrative documents Milestone 5 Estimated Incentive Payment: $ 372,140		**Milestone 8** [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients. Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a substance use disorder. Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for substance abuse disorder by 850 patients. Data Source: Medical Records; Project Data; Clinician Logs Milestone 8 Estimated Incentive Payment: $ 745,293 **Milestone 9:** [P-32]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At	**Milestone 10** [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients. Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a substance abuse or mental health disorder Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for substance abuse disorder by 904 patients. Data Source: Medical Records; Project Data; Clinician Logs Milestone 10 Estimated Incentive Payment: $ 616,102 **Milestone 11:** [P-32]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At

UNIQUE IDENTIFIER: 137265806.2.3 – PASS 3	RHP PP REFERENCE NUMBER 2.17.1	PROJECT COMPONENTS: 2.17.1 (A-G)	PROJECT TITLE: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS: SUBSTANCE ABUSE NAVIGATION	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI – 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.9 – Pass 3*	*IT-3.8*	*Behavioral Health/ Substance Abuse 30-day Readmission Rate*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 Estimated Incentive Payment: $ 460,710 **Milestone** 3 [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a substance abuse or mental health disorder Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for substance abuse disorder by 650 patients. Data Source: Medical Records; Project Data; Clinician Logs Milestone 3 Estimated Incentive Payment: $745,294	**Milestone 6:** [P-32]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment to implementing these improvements. Metric [P-32.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $372,140 **Milestone** 7 [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients.		each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment to implementing these improvements. Metric [P-32.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 9 Estimated Incentive Payment: $745,294	each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment to implementing these improvements. Metric [P-32.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 11 Estimated Incentive Payment: $616,103

UNIQUE IDENTIFIER: 137265806.2.3 – PASS 3	RHP PP REFERENCE NUMBER 2.17.1	PROJECT COMPONENTS: 2.17.1 (A-G)	PROJECT TITLE: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS: SUBSTANCE ABUSE NAVIGATION	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI – 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.9 – Pass 3*	*IT-3.8*	*Behavioral Health/ Substance Abuse 30-day Readmission Rate*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a substance abuse or mental health disorder Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for substance abuse disorder by 750 patients. Data Source: Medical Records; Project Data; Clinician Logs Milestone 7 Estimated Incentive Payment: $372,139			
Year 2 Estimated Milestone Bundle Amount: $1,382,129	**Year 3 Estimated Milestone Bundle Amount: $1,488,559**		**Year 3 Estimated Milestone Bundle Amount: $1,490,587**	**Year 5 Estimated Milestone Bundle Amount: $1,232,205**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $5,593,480				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Behavioral Health Assessment and Resource Navigation
PROJECT ID: 137265806.2.4 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): The Behavioral Health Assessment and Resource Navigation project creates a program to support uninsured individuals needing behavioral health care by providing free behavioral health assessments and referral to community treatment providers.

Need for the Project: Lack of timely, appropriate treatment taxes the medical provider system, through misuse of the emergency department, as well as community law enforcement (Austin Police Department Mental Health Deputies in particular). By providing free assessments and navigation, patients are able to access needed behavioral health services timely (CN.6).

Target Population: The Behavioral Health Assessment and Resource Navigation project will serve UMCB patients (inpatients and ED patients) who would benefit from a free behavioral health assessment. The project is expected to serve no less than the same payor mix reflected by UMCB as a whole: 21% Medicaid and 42% indigent.

Category 1 or 2 Expected Patient Benefits: This project will provide mental health disorder screenings and assessments for 240 patients in DY2, 1,560 patients in DY3, 2,000 patients in DY4, and 2,160 patients in DY5. In total, the project will serve approximately 5,960 patients (DY2 - DY5). Following the free assessment, patients will be navigated to services in the community.

Category 3 Outcomes: IT-3.8] Reduce by 3% in DY4 and by 5% in DY5, the 30-day readmission rate for participating UMCB inpatients with a principal or secondary diagnosis of mental health disorder and with a complete claims history for the 12-months prior to admission.

Title of Project: **Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Behavioral Health Assessment and Resource Navigation**

Category / Project Area / Project Option: **2.17.1**

RHP Project Identification Number: **137265806.2.4 – Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description:

The Behavioral Health Assessment and Resource Navigation project creates a program to support uninsured individuals needing behavioral health care by providing free behavioral health assessments and referral to community treatment providers.

Access to behavioral health services is limited for uninsured individuals within Travis County, with more than 8,000 Texans on a waiting list for community mental health services. The Texas average monthly number of persons receiving mental health crisis services each quarter is over 5,000 with an average monthly cost of $400 per person[87]. Lack of timely, appropriate treatment taxes the medical provider system, through misuse of the emergency department, as well as community law enforcement (Austin Police Department Mental Health Deputies in particular).

A free, comprehensive assessment of behavioral health needs will be administered to identified patients by licensed mental health professionals, who have been trained in completing and recoding computerized assessment information. Training will also include cultural competency, availability of community resources, hospitality, and service excellence. The assessment tool will be used to identify patients' strengths, needs, diagnostic profiles, and opportunities within the community for further behavioral health needs and care.

Following the free assessment, the Resource Navigation component of this project will follow up with assessed individuals to assist further in connecting the individual to services in the community. Uninsured individuals will be directed to schedule an appointment through referral sources within the community and the social workers at UMCB. For many patients, it is difficult to reach community providers, navigate through the application processes, and be accepted into treatment programs. This project will have collaborative relationships with a variety of community treatment providers, including Seton Mind Institute Behavioral Health Services Intensive Outpatient Program ("SMIBHS") which can, when no alternative community provider is available, provide the outpatient care to indigent individuals and Medicaid recipients. These relationships will aid in connecting individuals with behavioral health needs to timely, appropriate treatment in the most appropriate location. Without these navigation services, patients often become discouraged with the process and fail to follow through with treatment recommendations.

[87] TDSHS Behavioral Health Data Book. October 9, 2012.

The expected outcomes of the service are to (1) assist uninsured individuals who are seeking help for behavioral health issues gain knowledge of their illness through clinical assessment; (2) provide connection and referral to services available in the community; and (3) support individuals seeking help through connection with specialized services designed to address behavioral health issues, therefore reducing misuse of emergency departments at medical hospitals for behavioral health needs.

Goals and Relationship to Regional Goals:
The goal of the Behavioral Health Assessment and Resource Navigation project is to reduce unnecessary ED visits or hospitalization for uninsured individuals with behavioral health needs.

Project Goals: .

- Decreased utilization of the ED services or hospitalization (for behavioral health needs) through accurate referral and follow up post-assessment to assure the individual is able to received necessary services through community providers.
- Reduce ED visits or hospitalization (for behavioral health needs) of assessed individuals for Behavioral Health issues to 5% within 30 days of assessment.
- Increase the number of inpatients and ED patients who receive a screening and assessment for a mental health disorder.
- Avoid and/or reduce hospital admissions and ED utilization related to primary or secondary diagnosis of a mental health disorder for program participants.
- Reduce 30-day readmission rates of inpatients who are program participants.
- Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
- Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
- Bolster individual and population health by improving chronic disease management.
- Support prevention education and healthy lifestyles to improve population health.
- Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.
- Improve the patient experience of care by increasing the quality of care and patient safety.

This project meets the following regional goals:

- Regional Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Regional Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
- Regional Goal 6: Expand access to behavioral health services to ensure timely, effective treatment that minimized the use of crisis services and promotes recovery.

Challenges:
The greatest challenges include being able to meet the demand and need of the behavioral health population the program will serve due to the requirements of the program for staff and group meeting space. To address these challenges, the program will use current Seton staffing pools and

schedule group meetings based on when current space isn't being utilized. This may include scheduling additional group meetings in the evenings to accommodate the increased number of persons served.

5-Year Expected Outcome for Provider and Patients:
Through comprehensive assessment and accurate navigation of the behavioral healthcare system, UMCB expects to reduce behavioral health ED usage, greater patient satisfaction with overall behavioral health care, and reduced costs at UMCB and regionally. Over the five years of the demonstration, it is expected that 5,960 indigent and uninsured individuals will be screened and assessed for mental health disorders and provided with navigation services, which will connect them to specialized behavioral health services. This project will also provide navigation services to the patient and support shorter lengths of stay related and treatment options to inpatients and ED patients and reduce ED utilization.

Starting Point/Baseline:
This is a new project. Baseline is zero. Services will begin in DY2 and provide mental health screenings and assessments to 240 patients.

Rationale:
The purpose of the program will be to direct individuals toward early intervention and provide access to treatment opportunities and education for the indigent and uninsured Access to behavioral health services is limited for uninsured individuals within Travis County due to cost of services and a need for assistance in navigating to community services. By expanding access to free behavioral health assessments, more uninsured individuals will be given tools to educate individuals about their illness/needs, referrals to community treatment providers, and access to Resource Navigation to support connection to specialized services within the community.

Many of the assessed uninsured individuals will meet criteria to participate in an Intensive Outpatient Program at SMIBHS. Intensive outpatient services will support the goal of reducing the need for inpatient hospitalization at a behavioral health hospital.

The project will address the following:

- Identify frequent ED users and intervene with navigation as part of a preventable ED reduction program.
- Train health care navigators in cultural competency.
- Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
- Connect patients to primary and preventative behavioral health care services.
- Increase access to care management and/or chronic care management, including education in chronic disease self-management.
- Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Project Components:

This project will meet all of the required core components as follows:

a) *Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports.* A cross continuum team will be formed that includes participation from Emergency Department staff, social workers, psychiatry and Seton Mind Behavioral Institute (SMBHI) resource navigators.
b) *Conduct an analysis of the key drivers of the 30-day hospital readmissions for behavioral health conditions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR tool) and patient and provider interviews.* SMBHI has recently formed a Utilization Reduction Task Force that will be analyzing key drivers of inpatient admissions.
c) *Identify baseline mental health and substance abuse conditions at high risk for readmissions, (examples include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency).* The cross continuum team that will be formed as well as the Utilization Reduction Task Force will collaborate on identifying baselines.
d) *Review best practices for improving care transitions from a range of evidence-based or evidence-informed models.* The cross-continuum team that will be formed will review best practices.
e) *Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.* The Utilization Reduction Task Force will be undertaking this work.
f) *Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of:* The project will pilot care transition interventions for both ED and inpatient at-risk populations
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.* Provider will be participate in face-to-face learnings 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.

(Other) Conduct quality improvement. Other quality improvements will be considered based on learnings.

Unique community need identification numbers the project addresses:

- CN.4 - Inadequate access to behavioral health care
- CN.6 - Inadequate services throughout the continuum of care for individuals with behavioral health issues, such as:
    - Prevention and supported recovery
    - Screening, outpatient treatment, and integrated care
    - Intensive outpatient, supported housing, and residential treatment
    - Crisis stabilization services, detoxification services, medical/psychiatric, and inpatient care
- CN.7 - Lack of coordination of care across:
    - Settings of care
    - Multiple conditions
    - Physical and behavioral health

- CN.8 - High rates of non-emergent ED usage and potentially preventable inpatient admissions
- CN.15 - Additive and costly impact of co-occurring mental health, substance use, and medical conditions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a new initiative that focuses on providing behavioral health assessment and follow-up navigation services to uninsured individuals of Travis County.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project compliments, but does not duplicate other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measures:
OD-3 Potentially Preventable Re-Admissions 30-day Readmission Rates (PPRs)
IT-3.8 Behavioral Health/Substance Abuse 30-day Readmission Rate

Reasons/rationale for selecting the outcome measures:
Interventions such as assessment of behavioral health needs as a community initiative and linking patients with appropriate resources will lead to less hospital admissions and readmissions related to behavioral health.

The goals of the waiver are summarized through the triple aims of:

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care

The readmission rate for patients with a mental health disorder is currently very high. A hospital admission that might have been avoided with preemptive intervention is contrary to the. A readmission is a negative experience for the patient, resulting in missed work and lower quality of life. It increases the per capita costs of care, and does nothing to improve the health of the general population. A reduction in behavioral health-related admissions for participating inpatients will be a clear sign of its effectiveness.

Relationship to other Projects:
There are several projects within University Medical Center at Brackenridge that will supplement and support this project. Although these projects are related, they each provide different access points for interventions related to behavioral health incidents.

137265806.1.3 - Psychiatric Telemedicine
137265806.1.4 - Psychiatric Emergency Department
137265806.2.2 – Substance Abuse Navigation
137265806.2.4 - Chronic Care Management
137265806.2.6 - Care Transitions
137265806.X.X - Integrated BH Intervention for Targeted Chronic Disease Patients

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-1: Behavioral Health and Substance Abuse Admission rate
RD-2: Behavioral Health and Substance Abuse: 30-Day Readmissions

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
Mental health conditions are a great concern over the entire Region, as they tend to co-occur with other chronic diseases, leading to greater health care costs. Several projects propose interventions that would lead to better identification and navigation of behavioral health patients. Full integration of these services into the healthcare system will take efforts from many providers with related efforts, goals, and outcomes.

126844305.2.1 - Transitional Housing Guided by Peer Support
133340307.2.3 - Co-occurring Psychiatric and Substance Use Disorder
133340307.2.4 - Trauma Informed Care
133542405.2.2 - Expand Mobile Crisis Outreach Team - crisis intervention
133542405.1.3 - Expanded Access for Psych Services for Homeless Population at ARCH
133542405.2.5 - Health Promotion & Wellness for Chronic Disease in Behavioral Health Populations
201320302.2.1 - Provide ACT Model for Participants of HF PSH
186599001.1.1 - School Campus Counseling
307459301.2.1 - Community Care Collaborative - Patient-Centered Medical Home Project
307459301.1.1 - Community Care Collaborative - Implement/enhance and use chronic disease management registry functionalities
307459301.2.2 - Community Care Collaborative - Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions
307459301.2.3 - Community Care Collaborative - Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients
307459301.1.8 - Community Care Collaborative - Telepsychiatry in Federally Qualified Primary Health Clinics
307459301.2.6 - Community Care Collaborative - Community Paramedic Patient Navigation Program

The performing provider will fully participate in RHP-wide learning collaboratives for projects that directly address behavioral health issues. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically. In this instance, the providers could include:

Austin Travis County Integral Care - 133542405
City of Austin Health & Human Services Department – 201320302
Dell Children's Medical Center – 186599001

Project Valuation:

The project is valued using a method which ranks the importance of each project based on five factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; and (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in a cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE IDENTIFIER: 137265806.2.4 – PASS 3	RHP PP REFERENCE NUMBER 2.17.1	PROJECT COMPONENTS: 2.17.1 (A-G)	PROJECT TITLE: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS: BEHAVIORAL HEALTH ASSESSMENT AND RESOURCE NAVIGATION	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.10 – Pass 3*	*IT-3.8*	*Behavioral Health Substance Abuse Disorder 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]: Establish Task Force or Team to support or lead project. Metric 1 [P-1.1]: Establishment of Task Force or Team. Baseline: N/A Goal: Gather stakeholders for monthly meeting. Data Source: Meeting minutes. Milestone 1: Estimated Incentive Payment: $ 342,949 **Milestone 2:** [P-7]: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines. Metric [P-7.1]: Development of operations manual. Baseline: N/A	**Milestone 5:** [P-4]: Hire clinician (s) with care transition/disease management expertise. Metric 1 [P-4.1]: Position offer letter. Baseline: This is a new project baseline in DY3, for staff is 0 Goal: Hire one lead staff member. Data Source: HR documentation. Milestone 5: Estimated Incentive Payment: $ 369,358 **Milestone 6:** [P-3]: Identify baseline high-risk patients analyzing data regarding 30-day admissions for acute care patients. Metric [P-3.1]: Documentation of chart review. Goal: Produce report analyzing data. Data Source: Program Administrative documents Milestone 6: Estimated Incentive Payment: $ 369,358		**Milestone 9** [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients. Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a mental health disorder Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for a mental health disorder by 2,000 patients. Data Source: Medical Records; Project Data; Clinician Logs Milestone 9 Estimated Incentive Payment: $ 739,721 **Milestone 10:** P-32 Participate in face-to-face learnings at least twice per year with other providers and the RHP	**Milestone 11** [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients. Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a mental health disorder Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for a mental health disorder by 2,160 patients. Data Source: Medical Records; Project Data; Clinician Logs Milestone 11 Estimated Incentive Payment: $ 611,496 **Milestone 12:** P-32 Participate in face-to-face learnings at least twice per year with other providers and the RHP

UNIQUE IDENTIFIER: 137265806.2.4 – PASS 3	RHP PP REFERENCE NUMBER 2.17.1	PROJECT COMPONENTS: 2.17.1 (A-G)	PROJECT TITLE: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS: BEHAVIORAL HEALTH ASSESSMENT AND RESOURCE NAVIGATION	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.10 – Pass 3*	*IT-3.8*	*Behavioral Health Substance Abuse Disorder 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)
Goal: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines. Data Source: Program administrative documents Milestone 2 Estimated Incentive Payment: $ 342,949 **Milestone** 3 [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients. Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a mental health disorder Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for mental health disorder by 240 patients.	**Milestone 7** [I-X]: Customizable Improvement: Enhanced Screening and Assessment for inpatients and ED patients. Metric [I-X.1] Increase in target inpatient and ED population members screened and assessed for a substance abuse or mental health disorder Baseline: This is a new project, therefore baseline at DY2 is zero Goal: Increase inpatient and ED patients screened and assessed for substance abuse disorder by 1,560 patients. Data Source: Medical Records; Project Data; Clinician Logs Milestone 7 Estimated Incentive Payment: $ 369,357 **Milestone 8 :** P-32 Participate in face-to-face learnings at least twice per year with other providers and the RHP to		to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment to implementing these improvements. Metric P-32.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 10 Estimated Incentive Payment: $ 739,721	to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment to implementing these improvements. Metric P-32.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 12 Estimated Incentive Payment: $ 611,496

UNIQUE IDENTIFIER: 137265806.2.4 – PASS 3	RHP PP REFERENCE NUMBER 2.17.1	PROJECT COMPONENTS: 2.17.1 (A-G)	PROJECT TITLE: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS: BEHAVIORAL HEALTH ASSESSMENT AND RESOURCE NAVIGATION	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.10 – Pass 3*	*IT-3.8*	*Behavioral Health Substance Abuse Disorder 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: Medical Records; Project Data; Clinician Logs Milestone 3 Estimated Incentive Payment: $ 342,949 **Milestone 4:** P-32 Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment to implementing these improvements. Metric P-32.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting	promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment to implementing these improvements. Metric P-32.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 369,357			

UNIQUE IDENTIFIER: 137265806.2.4 – PASS 3	RHP PP REFERENCE NUMBER 2.17.1	PROJECT COMPONENTS: 2.17.1 (A-G)	PROJECT TITLE: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS: BEHAVIORAL HEALTH ASSESSMENT AND RESOURCE NAVIGATION	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure:	*137265806.3.10 – Pass 3*	*IT-3.8*	*Behavioral Health Substance Abuse Disorder 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)
agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $ 342,948				
Year 2 Estimated Milestone Bundle Amount: $1,371,795	**Year 3 Estimated Milestone Bundle Amount: $1,477,430**		**Year 4 Estimated Milestone Bundle Amount: $1,479,442**	**Year 5 Estimated Milestone Bundle Amount: $1,222,992**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $5,551,659				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Care Transition Intervention
PROJECT ID: 137265806.2.5 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project creates a multi-disciplinary team that monitors and coordinates the care of patients with chronic disease immediately following discharge from hospital to home, and from home to primary care. This project is expected to optimize the patient's recovery and avoid readmission. Services include home visits to provide short-term direct care, social services, behavioral health support, transportation, telehealth and patient training regarding self-care management of the chronic disease(s).

Need for the Project: This project proposes to enhance and expand an existing prototype program to better meet identified Regional needs related to the lack of care coordination across settings of care, between multiple conditions, and between physical and behavioral health needs (CN.7); the region's high rate of chronic disease (CN.9) and the limited access to transportation for low-income populations in urban areas (CN.5).

Target Population: We expect that this project will serve 7,500 patients over the life of the demonstration, of which 40-60% are expected to be indigent or Medicaid recipients. The target population is adult patients being discharged from UMCB with one or more illnesses such as Diabetes, Congestive Heart Failure, Asthma and COPD (target conditions) who also have a history of frequent hospital admissions and ED visits. *[Patients requiring a higher-level of intervention or have a lower hospital/ED utilization history will be referred to Performing Providers Chronic Care Management – Adults project, Seton Total Health Partners.]*

Category 1 or 2 Expected Project Patient Benefits: Of the patients identified as high risk and appropriate for this program, we expect to 75% will be served by this project by the end of Y5. This program began in DY1 serving 540 patients (baseline). Enrollments will increase by 1,084 patients in DY2, 1,459 patients in DY3, 1,834 patients in DY4 and by 2,583 patients in DY5. By the end of

DY5, enrollments will cumulatively total 7,500 patients. Please note that we expect a portion of program enrollees to leave the program and return in a subsequent year due to fluctuations in a patient's acuity level and/or eligibility criteria for the program; a re-enrollment will be counted as a new enrollment.

Category 3 Outcomes: IT-9.2 ED appropriate utilization - By the end of DY4, this project is expected to reduce ED visits for target conditions by Congestive Heart Failure, Diabetes, Cardiovascular Disease/Hypertension, and/or Chronic Obstructive Pulmonary Disease. 5% below the baseline rate established in DY3; a 10% reduction is baseline is expected in DY5

Title of Project: **Care Transitions Intervention**

Category / Project Area / Project Option: **2.12.1**

RHP Project Identification Number: **137265806.2.5 – Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description:
This is a care transition program that facilitates the transition of care from hospital to home and from home to primary care by educating and treating clients to support the management of specific chronic diseases for predominately individuals who are indigent or Medicaid recipients.

The Seton Care Transitions Intervention (SCTI) program was established in January 2012 to provide interventions and care coordination of persons with chronic disease to provide support following their discharge from hospital to home, and from home to primary care. This project is expected to optimize the patient's recovery and avoid preventable readmissions and inappropriate utilization of emergency departments (EDs).

Patients are identified during an acute care event and enrolled based on the presence of one or more chronic conditions, frequent admissions, and high resource use; specifically, patients admitted with Diabetes, Congestive Heart Failure (CHF), Asthma, and COPD will be targeted for the program. Once patients are identified and enrolled, home visits are provided by this multi-disciplinary team that focuses on both clinical and social determinants that are highly correlated with the probability of readmission and high resource expenditure. To assure continuity of care and patient safety, the program provides a minimum number of patient care transitions, a structured and monitored hand-off process, training for optimal self-care, and facilitated integration and access to follow-up care with primary physicians responsible for each patient's care.

The multi-disciplinary team comprised of advanced practice nurses, registered nurses, social workers, registered dietitians and respiratory therapists to provide support, care coordination and other interventions in patient homes, including short-term direct care, to ensure patients effectively, safely, and optimally transition to and remain in primary care, thus reducing the incidence of acute

symptoms and lowering resource use short-term direct care and This program also integrates existing social service, behavioral health, chemical dependency, and tele-health services from other program areas and incorporates these services into the home visit experience.

Goals and Relationship to Regional Goals:
By creating processes and care teams that focus on the effective and efficient transition of patients with chronic illness between care venues and on the reintegration with primary care, this project seeks to create an integrated delivery system that improves the overall health of RHP 7 populations and improved patient satisfaction, appropriate utilization, and reduced cost of care.

Project Goals:

- To reduce ED visits by improving management of chronic conditions and reduce the frequency of symptoms related to chronic illness
- To reduce length of stay during acute hospitalizations by ensuring adequate follow-up and primary care integration
- To reduce hospital readmissions by ensuring intentional hand-offs and coordination of care
- To improve access and attendance to primary care
- Increase the number of program participants receiving standardized, evidenced-based interventions per approved clinical protocols and guidelines.

This project meets the following regional goals:

- Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. (RHP Goal #1)
- Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate settings. (RHP Goal #2)
- Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. (RHP Goal #3)
- Bolster individual and population health by improving chronic disease management. (RHP Goal #4)
- Support prevention education and healthy lifestyles to improve population health. (RHP Goal #5)

Challenges:
The primary challenge for this project is proactively engaging vulnerable patients and primary care providers to significantly improve the management of complex chronic care and to coordinate care. This project is challenged to maintain ongoing relationships with both patients and providers that will enhance the continued management of the patient's disease.

This project addresses these challenges by focusing on rapid resolution to barriers by holding weekly case conferences that include all relevant providers. These case conferences target specific cases where the patient is at high risk of self-management failure or where integration with primary care has proven to be challenging.

5-Year Expected Outcome for Provider and Patients:

The project expects to successfully implement a chronic care management program that better meets the needs of seriously ill individuals with multiple chronic conditions to improves health outcome, lower provider costs by reducing avoidable hospital readmissions and emergency department visits and establish a medical home for 7,500 individuals.

Starting Point/Baseline:

This began with a prototype with a similar quasi-experimental design and began actively recruiting patients in January 2012. As of the beginning of October 2012, the clinic has enrolled approximately 540 patients; this number will be used as the baseline enrollment for subsequent enrollment goals.

Rationale:

The prevalence and high cost of unmanaged Diabetes, CHF, Asthma, and COPD within UMCB and throughout Region 7 has created a great need for this care transitions project. Recent studies demonstrate a link between the initiation of care transition programs and an improved adherence to chronic disease treatment therapy and self-care. As a result, participants realized an improved quality of life and a decreased financial burden due to downstream cost avoidance.

In our current healthcare system, patients too often receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner in partnership with a primary care medical home. Fragmentation in the healthcare system and lack of adequate communication between care providers 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, a lack of knowledge about what types of services can be provided in the primary care, and other psychosocial barriers that inhibit optimal care.

Effective and well-coordinated transitions of care result in a lower incidence of unplanned readmissions and lower healthcare costs. Voss et al concluded in a recent quasi-experimental prospective cohort study of 257 individuals that care transition interventions appears to be effective. This finding underscores the opportunity to improve health outcomes beginning at the time of discharge in open health care settings." (Voss R., 2011.)

A 2011 analysis of ED visits by uninsured and underinsured patients in Travis County conducted by Central Health found that almost 50% of ED visits were for services that could have been provided in a primary care setting. An additional 6% required emergent care, which potentially could have been prevented with appropriate ambulatory care. Similarly, planning data indicate that approximately 50% of patients in the Seton Edgar B. Davis Hospital ED, located in Caldwell County, could be seen in a more appropriate setting had preventive care, education, and disease management been better coordinated. In addition, adult residents of Region 7 have more than 8,500 potentially preventable inpatient hospitalizations per year for conditions such as bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and diabetes complications. Potentially preventable conditions requiring inpatient care contributed to over $1 billion in hospital charges between 2005 and 2010. Qualitative data collected through surveys and from providers indicate a need for better coordination across settings of care, including physical and behavioral healthcare systems.

Within the Seton Family of Hospitals, between July 1, 2009 and June 30, 2010, 3,684 under- and un-insured patients (6,344 visits) were seen with Diabetes, CHF, Asthma, COPD, or a combination of these diagnoses. These incidences had a direct expense of $5.7M, a negative contribution margin of $1.93M, and a negative net income of $6.5M.

Project Components:

a) *Review best practices from a range of models*: This project will leverage the best practices of BOOST and Coleman with enhancement designed to address the specific challenges and unique characteristic of the healthcare delivery system in RHP7.

b) *Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool*: Our internal team of epidemiologists, health economists, and statisticians has developed advance statistical methods for identifying and stratifying key drivers of readmission.

c) *Integrate information systems so that continuity of care for patients is enabled:* This project will leverage the regional level 7 HIE to integrate care coordination, home transition, EMR and hospital EHR data to create a longitudinal record of care.

d) *Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days:* We have implemented the LACE tool to stratify risk and interventions for patients being discharged to transitional care.

e) *Implement discharge planning program and post discharge support program:* Advance Practice Nurses working in the transitional care program meet with patients in our hospitals prior to discharge and coordinate the discharge plan and home regimen with hospital-based providers. This plan is then communicated to and coordinated with primary care providers upon discharge.

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:* The transitional care team consists of health coaches, registered nurses, medical doctors, advanced practice nurses, social workers, respiratory therapists, registered dietitians, project managers, and administrative staff who meet weekly to evaluate processes, data, patient outcomes, and program effectiveness.

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:* The program is monitored and evaluated by team statisticians and epidemiologists who provide monthly feedback on progress to achieve select CQI's. Program leaders and clinicians use these data and feedback, as well as field observations to continuously improve the care model to achieve the clinics outcome and performance objectives.

Unique community need identification numbers the project addresses:

CN.5 - Transportation access for people in the rural areas and for low-income populations in urban areas
CN.7 - Lack of coordination of care across settings of care, multiple conditions, and physical and behavioral health
CN.8 - High rates of non-emergent emergency department usage and potentially preventable inpatient admissions
CN.9 - High rates of chronic disease such as cardiovascular disease, cancer and rising rates of diabetes
CN.10 - Many residents in Region 7 have multiple chronic conditions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative that began with a prototype with a similar quasi-experimental design and began actively recruiting in January 2012. Enrollment at the end of DY1 was 540 patients and will be used as a baseline for subsequent enrollment goals.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project compliments, but does not duplicate funding other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measures:
OD-9 Right Care, Right Setting
IT-9.2 ED appropriate utilization -

- Reduce Emergency Department visits for target conditions (Congestive Heart Failure, Diabetes, Cardiovascular Disease /Hypertension, Chronic Obstructive Pulmonary Disease and Asthma) for the specific patient population served by the project.

Reasons/rationale for selecting the outcome measures:
Effective management of transitions in care has been shown to reduce inappropriate hospitalization and inappropriate use of emergency departments for the treatment of chronic illness. Measuring the incidence of emergency department use is an effective measure of the impact of a CTI program.

Relationship to other Projects:
There are several projects within UMCB that will supplement and support our proposal for Care Transition Intervention. Although these projects are related to this project, they each represent different points along the continuum of chronic disease care and, therefore, are not duplicative. For instance, patients requiring a higher-level of intervention or have a higher hospital/ED utilization history will be referred to our Chronic Care Management – Adults project. Additionally, program participants who are Spanish-speaking with limited English proficiency are expected to benefit from the Cultural Competency Training Program and the Language Resources Center project.

137265806.2.6 – Chronic Care Management – Adults
137265806.2.9 – Adult Diabetes Inpatient Chronic Care Management
137265806.1.4 – Language Services Resource Center
137265806.1.5 – Culturally Competent Care Training

List of Related Category 4 Projects
RD-2: Diabetes 30-Day Readmission
RD-2: All-Cause 30-Day Readmission
RD-3: Potentially Preventable Complications
RD-4: Patient Satisfaction

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

Projects proposed by other providers across the Region also relate to chronic care management. These projects either 1) expand primary or specialty care to facilitate disease management or 2) serve a different population.

201320202.2.2 – Expansion of Community Diabetes Project
186599001.2.2 – Chronic Care Management – Pediatrics
307459301.1.1 – Disease Management Registry
307459301.2.1– Patient-Centered Medical Home Project
307459301.2.2 – Expand Chronic Care Management Models
307459301.1.3 – Expand Primary Care via Mobile Health Clinics
307459301.1.7 – Expanded Specialty Care: Pulmonology
121789503.1.1 – Expanding Primary Care Capacity for Low-Income Residents of Hays County, TX

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

The performing provider will fully participate in RHP-wide learning collaboratives for projects that directly address care transitions and chronic disease management. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically. In this instance, the providers include:

City of Austin Health and Human Services Department – 201320202
Central Texas Medical Center – 121789503
Dell Children's Medical Center– 186599001

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE IDENTIFIER: 137265806.2.5 – PASS 3	RHP PP REFERENCE NUMBER: 2.12.1	PROJECT COMPONENTS: 2.12.1 (A-G)	PROJECT TITLE: DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS: CARE TRANSITIONS INTERVENTIONS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.11 – Pass 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.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions. Metric [P1.1] Care Transition protocols Goal Produce evidence protocols for effectively communicating with patients and families post-discharge to improve adherence to discharge and follow-up care instructions. Data Source: Completed protocol documentation **Milestone 1 Estimated Incentive Payment: $ 920,571** **Milestone 2** [P-5] Using a validated risk assessment tool, create a patient identification system Metric [P-5.1] Patient stratification system Baseline: NA	**Milestone 5** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric [I-11.1] Number over time of those patients in target population receiving standardized, evidenced-based interventions per approved clinical protocols and guidelines. Baseline: At the end of DY1, 540 patients were enrolled. Goal: 1,459 additional patients will be enrolled in the program and receive recommended education, care and services as dictated by approved and evidence-based care guidelines Data Source: Patient medical record reports and program analytics **Milestone 5 Estimated Incentive Payment: $ 1,982,919** **Milestone 6** [P-12]: Participate in face-to-face learnings at least twice per year with other providers and the RHP		**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 [I-11.1] Number over time of those patients in target population receiving standardized, evidenced-based interventions per approved clinical protocols and guidelines. Baseline: At the end of DY1, 540 patients were enrolled. Goal: 1,834 additional patients be enrolled in the program and receive recommended education, care and services as dictated by approved and evidence-based care guidelines Data Source: Patient medical record reports and program analytics **Milestone 7 Estimated Incentive Payment: $1,985,620** **Milestone 8** [P-12]: Participate in face-to-face learnings at least twice per year with other providers and the RHP	**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 [I-11.1] Number over time of those patients in target population receiving standardized, evidenced-based interventions per approved clinical protocols and guidelines. Baseline: At the end of DY1, 540 patients were enrolled. Goal: 2,583 additional patients will be enrolled in the program and receive recommended education, care and services as dictated by approved and evidence-based care guidelines Data Source: Patient medical record reports and programanalytics **Milestone 9 Estimated Incentive Payment: $1,641,428** **Milestone 10** [P-12]: Participate in face-to-face learnings at least twice per year with other providers and the RHP

UNIQUE IDENTIFIER: 137265806.2.5 – PASS 3	RHP PP REFERENCE NUMBER: 2.12.1	PROJECT COMPONENTS: 2.12.1 (A-G)	PROJECT TITLE: DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS: CARE TRANSITIONS INTERVENTIONS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.11 – Pass 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)
Goal: Produce a risk assessment tool and patient stratification report and description of provider utilization of report findings. Data Source: Written report. **Milestone 2 Estimated Incentive Payment: $ 920,571** **Milestone 3** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric [I-11.1] Number over time of those patients in target population receiving standardized, evidenced-based interventions per approved clinical protocols and guidelines. Baseline: At the end of DY1, 540 patients were enrolled. Goal: 1,084 additional patients will be enrolled in the program and receive recommended education, care and services as dictated by approved and evidence-based care guidelines.	to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment on implementing these improvements Metric [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Process Milestone 6 Estimated Incentive Payment: $1,982,920**		to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment on implementing these improvements Metric [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 8 Estimated Incentive Payment: $1,985,620**	to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment on implementing these improvements Metric [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 10 Estimated Incentive Payment: $1,641,427**

UNIQUE IDENTIFIER: 137265806.2.5 – PASS 3	RHP PP REFERENCE NUMBER: 2.12.1	PROJECT COMPONENTS: 2.12.1 (A-G)	PROJECT TITLE: DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS: CARE TRANSITIONS INTERVENTIONS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.11 – Pass 3*	*IT-9.2*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: Patient medical record reports and program analytics **Milestone 3 Estimated Incentive Payment: $ 920,571** **Milestone 4** [P-12]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comment on implementing these improvements Metric [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Process Milestone 4 Estimated Incentive Payment: $ 920,571**				

UNIQUE IDENTIFIER: 137265806.2.5 – PASS 3	RHP PP REFERENCE NUMBER: 2.12.1	PROJECT COMPONENTS: 2.12.1 (A-G)	PROJECT TITLE: DEVELOP, IMPLEMENT, AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS: CARE TRANSITIONS INTERVENTIONS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.11 – Pass 3*	*IT-9.2*	*ED appropriate utilization*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: $3,682,284	**Year 3 Estimated Milestone Bundle Amount: $3,965,839**		**Year 3 Estimated Milestone Bundle Amount: $3,971,240**	**Year 5 Estimated Milestone Bundle Amount: $3,282,855**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 14,902,217				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Chronic Care Management - Adults
PROJECT ID: 137265806.2.6 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County pop. 1.1 million), Texas and is known as the Region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This is a chronic care management program that provides direct health care and care coordination for adults who have been seriously injured and to those who have experienced a serious illness due to multiple chronic conditions.

Need for the Project: The Region has determined that patients with multiple chronic conditions have a higher risk of potentially preventable hospitalizations, contribute to higher costs of care and present a greater challenge for coordinated care (CN.7). Indigent and underinsured patients that seek treatment at UMCB often lack sufficient access to care to effectively manage multiple chronic conditions in an outpatient setting.

Target Population: The target population consists of adult patients discharged from UMCB that require a high level of medical intervention due to a seriously injury or due to a serious illness related to multiple chronic conditions that have resulted in frequent hospitalizations and/or emergency department visits. *[Patients requiring a lower-level of intervention or have a lower hospital/ED utilization history will be referred to the Care Transitions project, Seton Total Care Transitions.]* We anticipate that approximately sixty percent (60%) of program participants will be indigent or Medicaid recipients.

Category 1 or 2 Expected Patient Benefits: We expect to enroll 2,600 patients in the Seton Total Health Partners program by the end of DY5. This program began in DY1 serving 150 patients (baseline). Going forward, the program will have the capacity to serve a minimum of another 150 individuals in DY2, 500 DY3, 675 in DY4 and 1000 in DY5. Enrollments will increase by 225 in DY4 and by 300 in DY5. By the end of DY5, enrollments will cumulatively total 2,600. Please note that we expect a portion of program enrollees to leave the program and return in a subsequent year due to fluctuations in a patient's acuity level and/or eligibility criteria for the program; a re-enrollment will be counted as a new enrollment.

Category 3 Outcomes: This project will reduce ED utilization below baseline (established in DY3) by 5% in DY4 and 10% in DY5 for targeted conditions: Congestive Heart Failure, Diabetes, Cardiovascular Disease/Hypertension, and/or Chronic Obstructive Pulmonary Disease.

Title of Project: **Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Chronic care management for adults**
Category / Project Area / Project Option: **2.2.1**
RHP Project Identification Number: **137265806.2.6 – Pass 3**
Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**
Performing Provider TPI: **137265806**

Project Description:
This is a chronic care management program that provides direct care and care coordination for adults who have been seriously injured or have experienced a serious illness due to multiple chronic conditions.

The Seton Total Health Partners (STHP) program was established in January 2012 to help adults who have been seriously injured or who have experienced a serious illness due to multiple chronic conditions and evidence a history of multiple hospitalizations and high emergency department utilization. This program assists enrollees in finding and receiving the medical care they need to achieve optimal health and prevent avoidable hospitalization and the inappropriate utilization of emergency departments. The program provides a number of patient care interventions, a structured and monitored hand-off process, training for optimal self-care, counseling, and facilitated integration with primary and specialty physicians responsible for each patient's care.

All patients are enrolled in the program within one week of discharge from an inpatient hospital stay or ED through an intake process that provides a multidisciplinary assessment that addresses medical and social complexities, strengths and barriers, behavioral and psychiatric factors, access issues, and screenings (depression, quality of life, etc.) that impact the patient's health. Care is provided for an indefinite period of time in STHP clinics, the patient's home, homeless shelters or in any other setting conducive to accessing care. Services are provided by a physician-led multidisciplinary team of extensivists, nurse practitioners, social workers, registered dietitians, and community health promoters who implement an individualized, comprehensive plan of care. The program also addresses unmet healthcare needs and social barriers, such as obtaining medications, supplies and finding transportation to appointments. Upon discharge from the program, patients are linked with community clinics, specialty care, and other programs that serve indigent and Medicaid recipients and can manage their medical conditions over the long-term.

Goals and Relationship to Regional Goals:
The project seeks to improve the quality of care for the most complex and vulnerable patients in the community while at the same time innovating and integrating care as an initial step in the redesign of our local healthcare delivery system. Its goal is to provide patients with access to medical care, tools and information, promote optimal health, manage chronic conditions and improve self-care.

Project Goals:
- To reduce length of stay during acute hospitalizations by ensuring adequate follow-up and primary care integration
- To reduce hospital readmissions by ensuring intentional hand-offs and coordination of care
- To reduce ED visits by improving management of chronic conditions and reduce the frequency of symptoms related to targeted chronic illness: Congestive Heart Failure, Diabetes, Cardiovascular Disease/Hypertension, and/or Chronic Obstructive Pulmonary Disease.

- To improve access and attendance to primary care
- To create new or enhance existing primary care capacity

This project meets the following regional goals:

- Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. (Goal #1)
- Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. (Goal #2)
- Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. (Goal #3).
- Bolster individual and population health by improving chronic disease management. (Goal #4)

Challenges:
The primary challenge for this project is proactively engaging vulnerable patients and primary care providers to significantly improve the management of complex chronic care and to coordinate care. This project is challenged to maintain ongoing relationships with both patients and providers that will enhance the continued management of the patient's disease.

This project addresses these challenges by focusing on rapid resolution to barriers by holding weekly case conferences that include all relevant providers. These case conferences target specific cases where the patient is at high risk of self-management failure or where integration with primary care has proven to be challenging.

5-Year Expected Outcome for Provider and Patients:
The project expects to successfully implement a chronic care management program that better meets the needs of seriously ill individuals with multiple chronic conditions to improves health outcome, lower provider costs by reducing avoidable hospital readmissions and emergency department visits and establish a medical home for 2,600 individuals, the majority of which are indigent and Medicaid recipients who often face barriers care.

Starting Point/Baseline:
The STHP clinic began enrolling patients in January of 2012. As of the beginning of October 2012, the clinic has enrolled approximately 150 patients; this number will be used as the baseline enrollment for subsequent enrollment goals.

Rationale:
Based on analysis conducted by Region 7 partners, patients with multiple chronic conditions have a higher risk of potentially preventable hospitalizations, contribute to higher healthcare costs, and are a greater challenge for coordination of care.[88] Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition.[89] Moreover, almost 59% of Travis County patients with a mental

[88] U.S. Department of Health and Human Services (2012). Initiative on Multiple Chronic Conditions Retrieved July 2012 from http://www.hhs.gov/ash/initiatives/mcc.

[89] Analysis of 2011 data for safety net providers reporting to the Integrated Care Collaboration. Represents adults ages 18-64.

health diagnosis also experienced a co-occurring medical condition. An additional 20% had a substance abuse disorder, including 13% that had tri- morbid conditions (mental health, substance use disorder, and medical condition).[90]

Local data collected from UMCB in the period between July 1, 2010 and June 30, 2011, identified 8,800 unique individuals with one or more complex chronic conditions who received care at UMCB. These individuals collectively contributed to forty-four percent (44%) of the financial losses at UMCB during the same time period.

More than one in four Americans have multiple (two or more) comorbid chronic conditions[91]. Chronic illnesses are "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living."[92] In addition to comprising physical conditions, chronic conditions also include problems such as substance use and addiction disorders, mental illnesses, dementia and other cognitive impairment disorders, and developmental disabilities.

The prevalence of multiple chronic conditions among individuals increases with age and is substantial among older adults, even though many Americans with multiple chronic conditions are under the age of 65 years. As the number of chronic conditions in an individual increases, the risk of mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice also increases.[1,2,93,94,95] The resource implications for addressing multiple chronic conditions are immense: 66% of total health care spending is directed toward care for the approximately 27% of Americans with multiple chronic conditions.[1] Increased spending on chronic diseases among Medicare beneficiaries is a key factor driving the overall growth in spending in the traditional Medicare program.[96]

People with co-morbidities, including multiple physical health conditions and co-occurring physical and behavioral health concerns, require a variety of health care services that, when delivered in multiple locations by different providers, can lead to costly duplicative care that does not improve health outcomes. Goals identified by Region 7 partners include investing in patient-centered, integrated, comprehensive care that is coordinated across systems and reducing health system costs

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[90] Analysis by Children's Optimal Health of 2011 data for safety net providers reporting to the Integrated Care Collaboration.

[91] Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation, 2010. Available at http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf. Last accessed November 25, 2012.

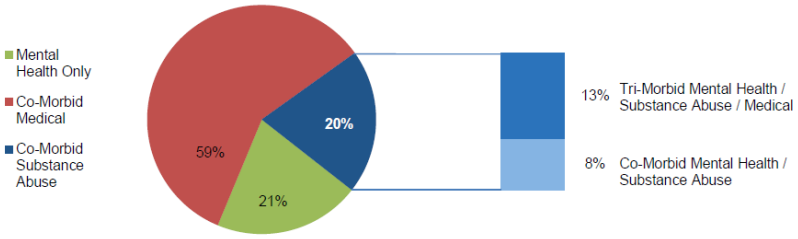
[92] Warshaw G. Introduction: advances and challenges in care of older people with chronic illness. Generation 2006;30(3):5–10.

[93] Lee TA, Shields AE, Vogeli C, Gibson TB, Woong Sohn M, Marder WD, Blumenthal D, Weiss KB. Mortality rate in veterans with multiple chronic conditions. J Gen Intern Med 2007;22(Suppl 3):403–407.

[94] Vogeli C, Shields AE, Lee TA, Gibson TB, Marder WD, Weiss KB, Blumenthal D. Multiple chronic conditions: prevalence, health consequences, and implications for quality, care management, and costs. J Gen Intern Med 2007;22(Suppl 3):391–395.

[95] Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch Intern Med* 2002;162(20):2269–2276.

[96] Thorpe KE, Ogden LL, Galactionova K. Chronic conditions account for rise in Medicare spending from 1987 to 2006. Health Affairs. 2010;29(4):1–7.



by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Project Components:
This project will meet all required core components as follows:

a) *Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system.* STHP provides individualized assessment of each patient's medical, social, and psychological needs and then tailors a plan of care customized to the patient's needs. This may include purchasing medications, providing transportation vouchers, and providing home visits to assess environmental factors or provide direct care in the home.

b) *Ensure that patients can access their care teams in person or by phone or email.* Each patient enrolled in the clinic is provided a 24/7 phone number to access his or her medical team. This phone queue is staffed by registered nurses supported by an escalation protocol developed by the STHP clinic. This protocol directs the phone center nurses on how and who to contact regarding the patient's care.

c) *Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources.* STHP assigns a community health promoter to each patient enrolled in the clinic. The promoter is responsible for meeting as often as is necessary with each patient to whom they are assigned. These encounters provide opportunity and venue for individualized education. Patients are also assigned a social worker who works directly with community resources and agencies to align services specific to the patient's needs. Group visit are provided to promote self-management skills and education.

d) *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.* Patients are provided ongoing support and education related to self-management of their conditions. Patients are also provided resources such as tobacco cessation counseling, diabetes education, alcohol rehabilitation, and other resources that may be determined necessary to achieve the patient's optimal health goals.

e) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.* The program is monitored and evaluated by team statisticians and epidemiologists who provide monthly feedback on progress to achieve select CQI's. Program leaders and clinicians use these data and feedback, as well as field observations to continuously improve the care model to achieve the clinics outcome and performance objectives.

Unique community need identification numbers the project addresses:
CN.1 - Inadequate access to primary care
CN.2 - Inadequate access to specialty care
CN.5 - Transportation access for people in the rural areas and also for low-income populations in urban areas
CN.7 - Lack of coordination of care across settings of care, multiple conditions and physical and behavioral health
CN.8 - High rates of non-emergent emergency department usage and potentially preventable inpatient admissions
CN.9 - High rates of chronic disease such as cardiovascular disease, cancer and rising rates of diabetes
CN.10 - Many residents in Region 7 have multiple chronic conditions
CN.15 - Additive and costly impact of co-occurring mental health, substance use, and medical conditions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is new program that was established In January 2012 to potentially transform the way care is provided to indigent and underinsured persons in Travis County diagnosed with serious, high acuity multiple chronic conditions.

This project compliments, but does not duplicate funding other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measures:
OD 9 Right Care, Right Setting.
IT-9.2 ED appropriate utilization

Reasons/rationale for selecting the outcome measures:
Effective management of chronic disease has been shown to reduce inappropriate hospitalization and inappropriate use of emergency department for the treatment of targeted conditions. Measuring the incidence of emergency department use is an effective measure of the impact of this program.
Related Activities Funded by U.S. Dept. of Health and Human Services.
This project compliments, but does not duplicate funding other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Relationship to other Projects:
There are several projects within UMCB that will supplement and support our proposal: the Care Transitions program (137265806.2.5) and the Adult Diabetes Management Program (13726580.2.9). Although these projects are related to this project, they each represent different points along the continuum of chronic disease care and, therefore, are not duplicative. For instance, patients requiring a lower-level of intervention or have a lower hospital/ED utilization history will be referred to our Care Transitions projects. Additionally, program participants who are Spanish-speaking with limited English proficiency are expected to benefit from the Cultural Competency Training Program (137265806.1.5) and the Language Resources Center project (137265806.1.4).

List of Related Category 4 Projects
RD-1: Potentially Preventable Admissions
RD-2: 30-Day Readmissions – all measures
RD-4: Patient Satisfaction

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
Projects proposed by other providers across the Region also relate to chronic care management. These projects either 1) expand primary or specialty care to facilitate disease management or 2) serve a different population.

307459301.2.1 - Patient-Centered Medical Home Project
307459301.1.1 - Implement/enhance and use chronic disease management registry functionalities
307459301.2.2 - Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions
307459301.1.7– Expanded Specialty Care: Pulmonology
201320202.2.2 – Expansion of Community Diabetes Project
121789503.1.1 – Expanding Primary Care Capacity for Low-Income Residents of Hays County, TX
186599001.2.2 – Chronic Care Management – Pediatrics

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City of Austin Health and Human Services Department – 201320202
Central Texas Medical Center – 121789503
Dell Children's Medical Center– 186599001
Community Care Collaborative – 307459301

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE IDENTIFIER: 137265806.2.6 – PASS 3	RHP PP REFERENCE NUMBER: 2.2.1	PROJECT COMPONENTS: 2.2.1 (A-E)	PROJECT TITLE: REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: CHRONIC CARE MANAGEMENT FOR ADULTS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure	*137265806.3.12 – Pass 3*	*IT9-2*	*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 [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option Metric. [I-21.1]: Increase percentage of target population reached. Baseline: At beginning of DY2, program enrollment was 150. Goal: Increase the percentage of the target population reached, by increasing program by 150 patients. (Cumulative program enrollment will be 300.) Data Source: Program enrollment records. **Milestone 1 Estimated Incentive Payment: $ 2,056,537** **Milestone 2** [P-16]: Participate in face-to-face learnings 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	**Milestone 3** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric [I-21.1]: Increase percentage of target population reached. Baseline: At beginning of DY2, program enrollment was 150. Goal: Increase the percentage of the target population reached, by increasing program by 150 patients. (Cumulative program enrollment will be 500.) Data Source: Program enrollmentrecords **Milestone 3 Estimated Incentive Payment: $ 2,214,901** **Milestone 4** [P-16]: Participate in face-to-face learnings 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		**Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric [I-21.1]: Increase percentage of target population reached. Baseline: At beginning of DY2, program enrollment was 150. Goal: Increase the percentage of the target population reached, by increasing program by 225 patients. (Cumulative program enrollment will be 625.) Data Source: Program enrollmentrecords **Milestone 5 Estimated Incentive Payment: $ 2,217,918** **Milestone 6** [P-16]: Participate in face-to-face learnings 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	**Milestone 7** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric [I-21.1]: Increase percentage of target population reached. Baseline: At beginning of DY2, program enrollment was 150. Goal: Increase the percentage of the target population reached, by increasing program by 300 patients. (Cumulative program enrollment will be 2600.) Data Source: Program enrollmentrecords **Milestone 7 Estimated Incentive Payment: $ 1,833,459** **Milestone 8** [P-16]: Participate in face-to-face learnings 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

UNIQUE IDENTIFIER: 137265806.2.6 – PASS 3	RHP PP REFERENCE NUMBER: 2.2.1	PROJECT COMPONENTS: 2.2.1 (A-E)	PROJECT TITLE: REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: CHRONIC CARE MANAGEMENT FOR ADULTS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Cat 3 Outcome Measure	*137265806.3.12 – Pass 3*	*IT9-2*	*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)
improvements. Each participating provider should publicly commit to implementing these improvements. Metric [P-16.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 2 Estimated Incentive Payment: $ 2,056,537**	should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric [P-16.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 4 Estimated Incentive Payment: $ 2,214,901**		should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric [P-16.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 6 Estimated Incentive Payment: $ 2,217,917**	should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric [P-16.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 8 Estimated Incentive Payment: $1,833,458**
Year 2 Estimated Milestone Bundle Amount: $4,113,074	**Year 3 Estimated Milestone Bundle Amount: $4,429,802**		**Year 3 Estimated Milestone Bundle Amount: $4,435,835**	**Year 5 Estimated Milestone Bundle Amount: $3,666,917**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,645,628				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Palliative Care
PROJECT ID: 137265806.2.7 PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project will create a new palliative care (PC) program devoted to providing palliative care to patients through a serious illness that may be chronic, terminal or acutely devastating. Services will be provided to inpatients and outpatients at UMCB, primary care clinics, patient homes and at specialty settings such as oncology, congestive heart failure and heart transplant clinics.

Need for the project: Before DY2, UMCB provided palliative care in a fragmented manner, sometimes without effective utilization of palliative care. This project will create a dedicated PC team to serve more patients and their families and provide palliative care services sooner into the course of an illness. Additionally, this project addresses community need CN.7 regarding the need for coordinated care.

Target population: This project is expected to serve 3,840 patients over the life of the demonstration. Over 1,200 patients per year are admitted with chronic diseases typically appropriate for palliative care consultations. The target population is persons admitted to UMCB or community clinics with chronic, often life-limiting diseases, such as cancer, congestive heart failure cirrhosis of the liver, COPD, dementia and end-state renal disease. We expect that this project will serves a similar ratio of patients who are indigent or have Medicaid as are currently treated at UMCB: 23% Medicaid and 37% indigent.

Category 1 or 2 expected patient benefits: This project will provide 939 palliative care consultations in DY2, 1,039 in DY3, 1,149 in DY4, and 1,279 in DY5. Total number of palliative care consultations served will be 4,397 (DY2-DY5).

Category 3 outcomes:

- [IT-13.1] By DY4, we seek to increase the percentage of palliative care patients who received a clinical assessment of pain within 24 hours of a pain screening by 5% above baseline established in DY3; and by 8% in DY5.
- [IT-13.2] By DY4, we expect to increase the percentage of seriously ill patients enrolled PC in an acute hospital setting whose patient chart documents preferences for life sustaining treatments by 7% above baseline in DY4 and 10% above baseline in DY5.
- [IT-13.6] We expect to increase the percentage of ICU patients who received a multidisciplinary family meeting from the palliative care team within 5 days of ICU admission by 3% in DY4 and by 5% in DY5.

Title of Project: **Use of Palliative Care Programs: Implement a Palliative Care Program to address patients with end of life decisions and care needs**

Category / Project Area / Project Option: **2.10.1**

RHP Project Identification Number: **137265806.2.7 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description

This project will create a new palliative care (PC) program devoted to providing palliative care to patients through a serious illness that may be chronic, terminal or acutely devastating.

The Palliative Care (PC) Expansion project encompasses a hospital-based palliative care program at University Medical Center at Brackenridge (UMCB) as well as outpatient programs and palliative care in other specialty settings such as oncology and CHF/transplant, outpatient primary care, and within the home. A primary goal of PC is to provide dignified, culturally appropriate care to un- and under-funded patients throughout a serious illness that may be chronic, terminal or acutely devastating. The project will also expand a dedicated palliative care team through the addition of physicians, nurses, social workers, and chaplains who will perform consultations, screenings, and assessment, and who will provide patients and care givers with psychosocial support.

Palliative Care (PC) is specialized medical care for people with serious illnesses and should not be confused with hospice. PC focuses on providing patients with relief from distressing symptoms (pain, shortness of breath, nausea, etc.) and other burdens of serious illness, whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. This is achieved with a multidisciplinary team of doctors, nurses and other specialists who work together with a patient's doctors to provide an extra layer of support. It is appropriate at any age, at any stage in a serious illness and can be provided along with curative treatment. It is not hospice which is meant exclusively for those with an expectedly brief life span.

These experts note that hospitals, nursing homes, and home health agencies need stronger incentives to provide better access to PC and care coordination either directly, themselves, or by contract with outside suppliers of hospice services[97]. It seems clear that improving care coordination can improve care for patients with chronic conditions.

Goals and Relationship to Regional Goals:

Over 1,200 patients per year are admitted with chronic diseases typically appropriate for palliative care consultations, including: cancer, congestive heart failure, cirrhosis, chronic obstructive pulmonary disease, dementia and end-stage renal disease.

Project Goals:

- Improve capacity to provide palliative care services to more inpatients and outpatients

a. [97] Zerzan, Stearns, & Hanson, 2000; Hanley, 2004

- Increase the number of ICU patients who received a multidisciplinary family meeting from the palliative care team within 5 days of ICU admission.
- Increase the number of clinical pain assessments performed for patients who screened positive for pain.
- Improved patient satisfaction
- Appropriate care, appropriate setting
- Reduced emergency department (ED) utilization
- Reduction in population specific Potentially Preventable Admissions
- Reduction in population specific Potentially Preventable Readmissions

This project meets the following regional goals:

***Regional Goal #2*: Reduced health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.** Palliative care has reduced costs and resources consumed in all the venues in which it has been engaged. For example PC saves $4900 in direct costs per admission to the hospital for patients receiving a PC consult[98] and jumps to $6900-7500 when applied to Medicaid patients[99]. These cost savings are accomplished by helping patients and families understand their illnesses and make informed choices with that understanding. In this way interventions that will not be beneficial are eliminated.

***Regional Goal #7:* Improve the patient experience of care by increasing the quality of care.** The Central Texas region, being underserved in this specialty, will enjoy new options for care. Comfort should not be a choice but rather emphasized throughout the patient's journey of care. The national data consistently demonstrates improved quality of life, a lessening of distressing symptoms, reduced healthcare resource utilization and costs, and even prolonged length of life.

A recent national report card for PC availability noted that Texas received the grade of "C"[100]. When taken as a nation the U.S. received a grade of "B." The area of central Texas currently does not have widespread access to hospital-based PC and no access at all to PC within clinics, nursing homes, the home, or other places of residence. Our project aims to build up the current PC program within the UMCB so that it might reach its full potential as well as create new availability across the spectrum of care (including the home) within this critical field.

Challenges:

Challenges include culture change and staffing issues. Medical care is traditionally disease centric and not person centric. PC is often linked to hospice and the time frame where patients are actively dying, rather than a specialty that should be part of care whether someone is in the early, middle, or late phase of an illness. PC is traditionally seen as a hospital (or inpatient) function and is not a part of outpatient care, creating a concern for funding in non-hospital settings. The PC workforce is severely shorted when it comes to providers with existing skills in this field potentially limiting rapid expansion.

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b. [98] Arch Intern Med 2008. 168(16):1783.
[99] Health Affairs 2011. 30(3):454-63.

c. [100] www.capc.org/reportcard

To address the challenges, performing provider will educate primary care and specialty practices (e.g. Family Medicine, Internal Medicine, Pediatrics, Geriatrics and other IM subspecialties) in providing PC and will also consider the use of PC medicine through pulmonary, cardiovascular, infectious diseases, oncology and renal subspecialties. Performing provider will implement PC education and training programs that incorporates management of non cancer patients for clinicians (physicians, RNs, PAs, NPs, and to other ancillary staff). Education will be offered to clinicians who are involved with chronic diseases and the associated chronic symptoms and management of these symptoms.

5 Year Expected Outcome for Provider and Patients*:

- Widespread emphasis of person-centered care
- Decreased family/caregiver distress for patients with serious illness
- New community standard for providers and patients for advance directives
- Decreased use of diagnostic studies and treatments that do not improve outcomes
- Increase the number of palliative care consultations

Starting Point/Baseline

UMCB has provide some palliative care for some time, however, this project creates a palliative care team, headed by a palliative care physician who was brought in this DY2 to design and revamp the existing service, dedicate resources, educate medical community and change the delivery of palliative care – providing not only to the dying, but also throughout the course of a disease. The target population is made up of persons who are identified as those under- and un-funded individuals qualifying for PC services. In DY1, 849 palliative care consultations were provided; this will be used as a baseline.

Rationale

Six imperatives are the foundation for supporting PC and promoting its growth outside the traditional hospital boundaries:

1) The epidemiology of aging and advanced illness. America is aging and at the same time becoming more ill. The 4 most common causes of adult deaths in the U.S. are from cardiac, malignant, progressive lung, and neurologic diseases[101], and become more prevalent as the population ages. The region encompassing Austin, Texas has the 2nd fastest growth for people over the age of 65 in the U.S[102]. There is concern that our current infrastructure, including the healthcare options, is inadequate to support a growing senior population[103].

2) Poor patient experience as a result of serious illness. For almost two decades the medical society has been aware of uncontrolled pain, anxiety, insomnia, shortness of breath, nausea and vomiting, depression, fatigue, and other treatable symptoms that haunt patients on a daily basis[104]. Despite this

[101] http://www.dartmouthatlas.org/

[102] http://impactnews.com/articles/growing-senior-population-may-bring-obstacles-to-austin-area-officials-say

d. [103] http://www.statesman.com/news/news/opinion/address-aging-austins-needs-now/nRmrJ/

e. [104] JAMA 1995. 274:1591-98.

awareness little work has been done to create widespread change even though studies support that when trained teams aggressively treat these symptoms, they improve significantly[105].

3) Shifting ideology of medical care. Healthcare providers have been trained to be disease-centered rather than patient-centered. The "procedure" performed by PC is the family meeting where empathy, conflict resolution, active listening, and other techniques are employed to create a more holistic, person-centered ultimate outcome[106].
4) Caregiver syndrome. There are over 40 million caregivers in the US who share in responsibility for the wellness of patients. These care givers are typically female, employed, rate their own health as poor, and likely to be family members[107]. Studies show that they feel neglected in the healthcare journey of the patient. They are not satisfied with care for serious illnesses, would like to voice their concerns more than they are able, want to feel included, and wish for more access to the providers[108]. Caregivers also have worsening health, higher healthcare costs, and increased risk of death compared to non-caregivers[109]. PC is the only medical specialty that defines itself by treating the patient and caregiver as a unit and has a formalized, evidence-based approach to dealing with caregiver concerns.

5) Unsustainable rising US healthcare costs. Between 25% to one-third of Medicare dollars are spent during the last year of life[110]. The World Health Organization has ranked the U.S. as 37th in the world when it comes to performance[111]. Palliative care has reduced costs and resources consumed in all the venues in which it has been engaged. For example, PC saves $4900 in direct costs per admission to the hospital for patients receiving a PC consult[112] and jumps to $6900-7500 when applied to Medicaid patients[113].

6) Recognition and presence of PC in the industry. As palliative care has been demonstrated to decrease suffering, improve satisfaction, support caregivers, and save money, a plethora of organizations, professional societies, and media have embraced palliative care as a champion in healthcare reform.

Project Components:

Through the Palliative Care Program, we propose to meet all required project components:

a) *Develop a hospital specific business case for PC and conduct planning activities necessary as a precursor to implementing a PC program.* Studies have established that PC reduces the cost of care. It is widely accepted in the field that planning activities are necessary to establish successful PC programs[114]. Substantial work has been done on a business plan for expansion of Palliative Care Services at UMCB and planning activities have been conducted for this project. We will also be conducting

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f. [105] NEJM 2010. 363:733-42.
g. [106] Arch Intern Med 2007. 167:453-460.
h. [107] www.caregiving.org
i. [108] JAMA 2004. 291:88-93.
j. [109] J Clin Oncol 2009. 27:1-7.
k. [110] Center for Medicare & Medicaid Services, Office of the Actuary, *Last Year of Life Study*
l. [111] http://www.who.int/whr/2000/media_centre/press_release/en/
m. [112] Arch Intern Med 2008. 168(16):1783.
[113] Health Affairs 2011. 30(3):454-63.

n. [114] www.med-ic.org/pdf/PC1.pdf

a needs assessment and gap analysis, including assessment of the need for expanding services to outpatient settings, and will prepare a recommendation and business case for it.

b) *Transition PC patients from acute hospital care into home care, hospice or a Skilled Nursing Facility (SNF).* A goal of PC is to minimize transfers to ICUs, stays in the hospital, and discharges to home with no services, while maximizing patient transitions to home care, hospice and SNF. Currently, the PC program provides transition planning and care for a limited number of patients. As the program expands with a full-time physician, RN and program assistant, it is anticipated that additional patients will receive services to transition to settings that meet their preferences and clinical needs.

c) *Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time.* PC has been proven to result in increased patient and family satisfaction[115]. In DY2, we are developing the survey instrument and process for assessing the patient/family experience for the PC program.

d) *Conduct quality improvement for PC project using methods such as rapid cycle improvement.* We will conduct quality improvement activities with other providers and the RHP to promote collaborative learning around shared or similar projects. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Unique community need identification numbers the project addresses:

CN.7 – Lack of coordination of care across: settings of care, multiple conditions, physical and behavioral health

CN.8 – High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

CN.9 – High rates of chronic disease such as: cardiovascular disease, cancer, rising rates of diabetes

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

Palliative care has been provided at UMCB to some extent care, however, this project creates a palliative care team, headed by a palliative care physician who was brought in this DY2 to design and revamp the existing program, dedicate resources, educate medical community and change the delivery of palliative care – providing not only to the dying, but also throughout the course of a disease.

Related Activities Funded by U.S. Dept. of Health and Human Services.

This project compliments, but does not duplicate other initiatives funded by U.S. Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measure(s)

OD-13 Palliative Care

IT-13.1 Pain Assessment (NQF 1637)

IT-13.2 Treatment Preferences (NQF 1641)

IT-13.6 Other Outcome Improvement Measure (NQMC:002702)

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o. [115] www.kaisersantarosa.org/palliativecarestudy

Reasons/rationale for selecting the outcome measures:
Pain assessment was chosen because of its link to appropriate utilization of care. High utilization of emergency department and inpatient services have been linked to uncontrolled symptoms, pain being one of the most common[116,117].

Treatment Preferences was chosen because research has shown that when trained professionals have conversations with patients and their families about treatment preferences, and the patient/family wishes are followed, symptom scores diminish, quality of life scores improve, family/caregiver stress lessens, fewer healthcare resources are consumed, and cost of care declines.
This measure was chosen because Palliative care focuses on prevention and relief of suffering, improving communication, between treatment and individual preferences, and facilitating transitions across care settings for patients with life threatening illness and their families. As such, it is increasingly accepted as an integral component of comprehensive intensive care unit (ICU) care for all critically ill patients, including those pursuing every reasonable treatment to prolong life.

Relationship to Other RHP Projects

List of Related Category 1 & 2 Projects *(RHP Project ID Number)*
While there are no other specific Palliative Care projects, there other projects that share the focus - transitions between settings of care and reducing potentially avoidable admissions and readmissions. Furthermore, this project helps to provide patients comfort during difficult and vulnerable time period in their lives. Projects related to demonstrating awareness and sensitivity to unique cultural differences includes the following: 137265806.1.4: Language Services Resource Center, and 137265806.1.5: Culturally Competent Care Training.

List of Related Category 4 Projects
RD-2.7. All-Cause: 30-Day Readmission; RD-3; Potentially Preventable Complications; RD-4.1. Patient Satisfaction; RD-4.2. Medication Management

Relationship to Other Performing Providers' Projects in the RHP

No other performing providers in the RHP are proposing similar projects. Performing provider will reach out to providers in other regions who are pursuing other palliative care projects.

Plan for Learning Collaborative

While other providers are not pursuing Palliative Care projects, they do share project focus - transitions between settings of care and reducing potentially avoidable admissions and readmissions. As such, the performing provider will fully participate in RHP-wide learning collaboratives with providers that have projects providing navigation services to patients. These annual meetings should include discussions of local patterns in care transitions and utilization, innovations for procuring relevant data, and the impact of these projects on the associate populations. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project

[116] J Pain Symptom Manage 2010. 39:1801-85.
[117] J Clin Oncol 2011.34.2816-2823.

throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically.

Project Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE IDENTIFIER: 137265806.2.7 – PASS 3	RHP PP REFERENCE NUMBER 2.10.1	PROJECT COMPONENTS: 2.10.1 (A-D)	PROJECT TITLE: USE OF PALLIATIVE CARE PROGRAMS: IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				TPI: 137265806
Related Category 3 Outcome Measure(s):	137265806.3.13 – Pass 3 137265806.3.14 – Pass 3 137265806.3.15 – Pass 3	IT-13.1 IT-13.2 IT-13.6	Pain Assessment Treatment Preferences Other Outcome Improvement Measure	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Develop a hospital-specific business case for PC and conduct planning activities necessary as a precursor to implementing/expanding a PC program. Metric [P-1.1]: Business Case Goal: Produce business case for next phase of palliative care program. Data Source: Business case write-up; documentation of planning activities **Milestone 1 Estimated Incentive Payment:** $391,704 _____ **Milestone 2** [P-5]: Implement/expand a PC program. Metric [P.5-1:] Implement comprehensive palliative care program. Baseline: As of 9/30/12, total staff: 2 Advance Practice Nurses; 1 Physicians Goal: Hire 1 FTE Program Coordinator and 1 FTE Clinical Operations Manager	**Milestone 5**[P-4]: Develop an electronic system (e.g. a rounding tool or a registry or software) that analyzes the PC system data to determine if the program is effective. Metric [P-4.1]: EHR system implementation with capacity for palliative care registry and metric analysis Goal: Implement electronic system with capacity for palliative care registry and metric analysis. Data Source: Documentation of EHR capacity and use **Milestone 5: Estimated Incentive Payment:** $562,489 _____ **Milestone 6**[P-11.1]: Participate in face-to-face learnings 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	**Milestone 8**[I-12]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time. Metric [I-12.1]: Survey developed and implemented; scores increased over time Goal: Improve patient and family satisfaction levels. Data Source: Patient/family experience survey. **Milestone 8: Estimated Incentive Payment:** $563,256 _____ **Milestone 9**[P-11.1]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to	**Milestone 11** [I-X]: Improved access to palliative care services to inpatients and outpatients Metric [I-X.1]: Demonstrate improvement over prior reporting period Baseline: 849 Palliative care consultations in DY1 Goal: 1270 of palliative care consultations Data Source: Patient registry, claims or other provider documentation **Milestone 11 Estimated Incentive Payment:** $698,429 _____ **Milestone 12**[P-11.1]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating

UNIQUE IDENTIFIER: 137265806.2.7 – PASS 3	RHP PP REFERENCE NUMBER 2.10.1	PROJECT COMPONENTS: 2.10.1 (A-D)	PROJECT TITLE: USE OF PALLIATIVE CARE PROGRAMS: IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			TPI: 137265806
Related Category 3 Outcome Measure(s):	137265806.3.13 – Pass 3 137265806.3.14 – Pass 3 137265806.3.15 – Pass 3	IT-13.1 IT-13.2 IT-13.6	Pain Assessment Treatment Preferences Other Outcome Improvement 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)
Charter for Palliative care program; Operational Plan; palliative care team and hiring agreements **Milestone 2 Estimated Incentive Payment:** $391,704 _____ **Milestone 3** [P-11]: Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-11.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 3 Estimated Incentive**	should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. **Metric [**P-11.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Goal:** Participate in face-to-face learning at least twice per year **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 6Estimated Incentive Payment:** $ 562,489 **Milestone 7** [I-X]: Improved access to palliative care services to inpatients and outpatients Metric[I-X.1]: Demonstrate improvement over prior reporting period Baseline: 849 Palliative care consultations in DY1 Goal: Provide 1039 of palliative care	implementing these improvements. Metric [P-11.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in face-to-face learning at least twice per year **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 9Estimated Incentive Payment:** $ 563,255 **Milestone 10** [I-X]: Improved access to palliative care services to inpatients and outpatients Metric [I-X.1]: Demonstrate improvement over prior reporting period Baseline: 849 Palliative care consultations in DY1. Goal: 1149 of palliative care consultations Data Source: Patient registry, claims or other provider documentation **Milestone 10 Estimated Incentive**	provider should publicly comments to implementing these improvements. Metric [P-11.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 12Estimated Incentive Payment:** $698,428

UNIQUE IDENTIFIER: 137265806.2.7 – PASS 3	RHP PP REFERENCE NUMBER 2.10.1	PROJECT COMPONENTS: 2.10.1 (A-D)	PROJECT TITLE: USE OF PALLIATIVE CARE PROGRAMS: IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				TPI: 137265806
Related Category 3 Outcome Measure(s):	137265806.3.13 – Pass 3 137265806.3.14 – Pass 3 137265806.3.15 – Pass 3	IT-13.1 IT-13.2 IT-13.6	Pain Assessment Treatment Preferences Other Outcome Improvement Measure	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Payment: $391,704 **Milestone 4** [I-X]: Improved access to palliative care services to inpatients and outpatients Metric [I-X.1]: Demonstrate improvement over prior reporting period Baseline: 849 Palliative care consultations in DY1 Goal: Provide 939 palliative care consultations Data Source: Patient registry, claims or other provider documentation **Milestone 4 Estimated Incentive Payment:** $ 391,703	consultations Data Source: Patient registry, claims or other provider documentation **Milestone 7 Estimated Incentive Payment:** $562,489		**Payment:** $563,255	
Year 2 Estimated Milestone Bundle Amount: $1,566,815	**Year 3 Estimated Milestone Bundle Amount $1,687,467**		**Year 4 Estimated Milestone Bundle Amount: $1,689,766**	**Year 5 Estimated Milestone Bundle Amount: $1,396,857**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $6,340,905				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Women's Oncology Care Navigation
PROJECT ID: 137265806.2.8 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.

Intervention(s): This project expands existing patient navigation services that connect women with cancer diagnosis to treatment and/or survivorship support services.

Need for the Project: This project is designed to overcome health care system barriers and to facilitate improved access to quality medical and psychosocial care, linkage to a medical home and survivor support services (CN.7).

Target Population: This project seeks to serve Travis County women who are 1) receiving treatment for gynecologic cancer (ovarian, uterine, and cervical) at the Shivers Cancer Center Gynecologic Oncology Clinic; and 2) age 40+ and are survivors of breast or gynecologic cancer or who are at high risk of disconnect from institutionalized healthcare. The estimated indigent or Medicaid population is 25%.

Category 1 or 2 Expected Patient Benefits: This is a new project; baseline in zero. The program will serve 1479 women in DY2, 1971 in DY3, 2528 in DY4, and 3312 in DY5; cumulative program enrollment will be 9290 (DY2 through DY5). Please note that we expect a small portion of program enrollees to leave the program and return in a subsequent year; a re-enrollment will be counted as a new enrollment.

Category 3 Outcomes: [IT 9.2] This project will reduce ED utilization for program participants 3% below baseline in DY4 and 5% below baseline in DY5. Baseline to be determined in DY3.

Title of Project: **Women's Oncology Care Navigation**

Category / Project Area / Project Option: **2.9.1**

RHP Project Identification Number: **137265806.2.8 – Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description:
Performing Provider proposes to expand existing patient navigation services for indigent and under-insured women receiving cancer treatment and/or survivorship support.

This project will serve women being treated for breast and gynecologic (ovarian and uterine) cancer at UMCB and its outpatient cancer clinic, Shivers Cancer Center. This project also expands support to survivors of breast and gynecological cancer in Travis County, ages 40 and over.

Oncology navigators are the linchpin of our patient-centered, multi-disciplinary support team treating patients with breast and gynecological cancers. This team includes registered nurses, social workers, nutritionists, spiritual care providers, and occupational therapists. Navigators assess patients for psychosocial distress using the National Comprehensive Cancer Network Distress Thermometers. Social service needs, including basic necessities such as food and shelter, are also addressed through this project. Navigators then coordinate the patient's connection with treatment and support services and work collaboratively with the clinical and support teams. Navigators also visit patients in the hospital and/or work with case management to ensure a smooth hand-off to outpatient treatment.

At the completion of each patient's initial treatment course, the navigator creates a survivorship plan for physician approval. The plan incorporates a nationally recognized survivorship plan tool and includes a treatment summary, follow-up plan, indications for emergency department (ED) use and wellness activities. Navigation and other services, e.g. social work, nutrition counseling, will be provided based on the plan. The plan, to be available in English and Spanish, is provided to both the patient and her primary care provider and its execution is monitored by the navigator. Patients without a primary care provider are linked to a primary care medical home. Navigators also link patients with health coverage and specialty care for surveillance of long-term side effects of treatment.

Goals and Relationship to Regional Goals:
This project is designed to overcome health care system barriers and to facilitate improved access to quality medical and psychosocial care, to include linking patients to a medical home and survivor support services.

This project meets the following regional goals:

- Reduce health systems costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. (RHP Goal #2)

- Improve the patient experience of care by investing in patient-centers, integrated, comprehensive care that is coordinated across systems. (RHP Goal #3)

Challenges:
The project will require engaging and building trust with patients. We will address this challenge by hiring culturally and linguistically competent Navigators, ensuring they receive proper training and have access and support from clinic and hospital based clinicians and administrators to resolve barriers patients encounter.

It may be difficult to find primary care providers who will accept new indigent, low income and Medicaid patients, particularly patients who do not qualify for the local Medical Assistance Program. To address this challenge, specific efforts will be made to collaborate with the Travis County safety net clinic systems (i.e. Seton Community Health Centers, CommUnitycare, Peoples, El Buen, Lone Star Circle of Care, Volunteer Clinic, etc.), and others, to their encourage participation in the project.

5-Year Expected Outcome for Provider and Patients:
We expect to identify gaps in services of women during and after their treatment for breast and gynecologic cancer and develop a program that will increase access to timely care, optimize the delivery of care, and improve health outcomes. By the end of the 5-year period, UMCB expects to provide trained patient navigators andwill have provided services to 9290 women. Through effective navigation services, education and support, we expect to reduce the rate of ED utilization for program participants.

Starting Point/Baseline:
Because this project expands navigation services to new populations and combines two existing populations, no metrics for the project's proposed population exists and the baseline is zero.

Rationale:
RHP #7's Community Needs Assessment reports that cancer is the second leading cause of death in the region and the leading cause of death in Travis County. Breast cancer was the most common cancer in the county and the third leading cause of death 2005-2009. [118] The numbers of gynecologic cancers in Travis County is about one-third of breast cancer. [119] Seton's Cancer Registry shows a higher proportion of gynecologic cancers, with 62 newly diagnosed breast cancer and 44 new gynecologic cancers in 2011. The population of Travis County survivors of breast and gynecologic cancers in just the Seton registry is much higher—314 breast and 120 gyn/onc respectively diagnosed in 2010 and alive today.[120] This project is a significant expansion of existing navigation services that will increase the number of women served throughout the continuum of breast and gynecologic cancer care.

[118] Texas Cancer Registry, 2012 Selected Cancer Facts Texas: Travis County http://www.dshs.state.tx.us/tcr/factsheet_county.shtm

[119] Texas Cancer Information, http://texascancer.info/scripts/mgwns.html, most recent data is 2007.

[120] Data from 6 Seton facilities, not just UMCB/Shivers patients alive and diagnosed in 2010.

Patient navigation services[121] are an essential component of quality cancer care.[122], [123] The Commission of Cancer Program Standards of 2012, include the provision of a cancer survivorship plan.[124] The Commission grounded this standard in research that recommends that patients with cancer who are completing the first of course treatment be 'provided with a comprehensive care summary and follow-up plan that is clearly and effectively explained.' The recommendation suggested that these plans would help cancer survivors who may otherwise get "lost" in the transitions from the care they received during treatment through the phases of their life or stages of their disease course."[125] [126] Survivorship plans also are of value to primary care providers.[127]

Additionally, patients having a primary care home is the foundation for transforming health care delivery from a disease-focused model of episodic care to a patient-centered coordinated deliver model that improves health outcome. Research is beginning to show its value for cancer survivors. [128] [129]

Project Components:

a) *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* We expect the majority of persons enrolled in the program will be from direct referrals from the treating providers in connection with oncology treatment and/or discharge planning. This project will include working with ED case managers to develop a referral tool to identify potential program participants and connect them with the program. Navigators will work with program participants to assess on-going care needs and provide follow-up and support services, in an effort to obtain care in the appropriate setting and reduce preventable ED visits. Patient Navigators will undergo training in providing culturally competent care and receive education regarding disparities and social determinants of health outcomes.

b) *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* We plan to pair community health workers, experienced with

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[121] Patient navigation services refer patients, families and caregivers to overcome health care system barriers and facilitate timely access to quality medical and psychosocial care and occur from prior to a cancer diagnosis through all phases of the cancer experience. Commission on Cancer, Cancer Program Standards 2012: Ensuring Patient-Centered Care. http://www.facs.org/cancer/coc/cocprogramstandards2012.pdf

[122] 1999 Institute of Medicine (IOM) study *Ensuring Quality Cancer Care.*

[123] Id. at FN4

[124] Id. at FN4

[125] *From Cancer Patient to Cancer Survivor: Lost in Transition, IOM and National Research Council, 2005.*

[126] Id at FN4

[127] J Oncol Pract. 2011 Sep;7(5):314-8.Do survivorship care plans make a difference? A primary care provider perspective. Shalom MM, Hahn EE, Casillas J, Ganz PA.

[128] J.Oncol Pract. 2012 May;8(3):184-9. Epub 2012 Jan 24.Providing care for cancer survivors in integrated health care delivery systems: practices, challenges, and research opportunities.Chubak J, Tuzzio L, Hsu C, Alfano CM, Rabin BA, Hornbrook MC, Spegman A, Von Worley A, Williams A, Nekhlyudov L.

[129] J Cancer Surviv. 2012 Jul 10. [Epub ahead of print] Models of care for post-treatment follow-up of adult cancer survivors: a systematic review and quality appraisal of the evidence. Howell D, Hack TF, Oliver TK, Chulak T, Mayo S, Aubin M, Chasen M, Earle CC, Friedman AJ, Green E, Jones GW, Jones JM, Parkinson M, Payeur N, Sabiston CM, Sinclair S.

providing direct care to disadvantaged populations, with Registered Nurses with disease-specific skills to provide patient navigation services

c) *Connect patients to primary and preventive care.* One of the primary goals of this project is to link patients with a medical home, including scheduling first appointments and follow-up to assure appointment was made. Provider will build on existing relationships with safety net primary care providers to identify and establish collaborative relationships with primary care and preventive care providers who will serve this population.

d) *Increase access to care management and/or chronic care management, including education in chronic disease self-management.* The care team will be trained to assess enrollees to identify care management needs and provide disease education and self-care management in both English and Spanish. The team will also provide self-care supplies for patients in need.

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.* Performing Provider will conduct periodic internal coordination meetings between multiple areas of the health system and externally with other healthcare providers and non-healthcare partners in the community to identify best practices and implement or pilot new ideas.

Unique community need identification numbers the project addresses:

CN.1 – Inadequate access to primary care

CN.7 - Lack of coordination of care across:

- Settings of care
- Multiple conditions
- Physical and behavioral health

CN. 9 - High rates of chronic disease such as:

- Cardiovascular disease
- Cancer
- Rising rates of diabetes

CN.17 - Increasing diversity of the region, exacerbating the existing racial and ethnic disparities across many health conditions

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

With the addition of staff, this project expands patient navigation services to indigent and underinsured patients of the region's largest safety-net hospital. This project also enlarges an existing navigation program for cancer survivors ages 19-38, to women with breast and gynecological centers age 40 and over.

Related Activities Funded by U.S. Dept. of Health and Human Services

This project compliments but does not duplicate funding received for other initiatives by the U.S. Department of Health and Human Services either directly or indirectly or through the state.

<u>Related Category 3 Outcome Measures:</u>

OD-9 Right Care, Right Setting
IT 9.2 ED appropriate utilization: reduce all ED visits

Reasons/rationale for selecting the outcome measures:
This measure was selected because interventions by navigators can help reduce ED use. EDs are often used by patients with cancer for disease or treatment-related problems and unrelated issues. The Institute of Medicine report on ensuring quality cancer care provided a review of cancer services and delivery systems and identified a "wide gulf between what could be construed as the ideal and the reality of their experience with cancer care."[130] One recommendation from the report was the need to conduct studies on why segments of the population do not receive appropriate cancer care. Visiting the ED may be considered appropriate care when assessing and managing acute onset problems but may also reflect problems not adequately addressed or managed during routine cancer care.[131] In addition, EDs are often overcrowded and are providing care to larger numbers of patients; this might not be the best environment for oncology patients with urgent care needs.

Interventions by navigators are expected to reduce ER use. Nursing intervention focusing on educating cancer patients regarding specific strategies for controlling symptoms may be worthwhile, as the patients may regain some control in managing their symptoms and thus ultimately require fewer ED and hospital visits. Such a straightforward approach may empower patients, enhance their quality of life and reduce overall costs of cancer care.[132] Nurses can help ensure common reasons for ED usage are addressed, e.g. pain, GI symptoms and prevent symptoms from escalating to the need for ED service. They also can provide education on how to recognize infection and help empower them to control symptoms and thus reduce ED use.[133] By providing the navigation services provided by this project, we expect the incidence of ED by program participants to decline and the use of this measure an effective measure of the impact of this program.

Relationship to other Projects:
This project is related to UMCB's Women's Oncology Screening project and together these projects provide services across the continuum of care for oncology patients. While this project targets women in treatment and post-treatment, the screening project targets women before treatment, therefore the two projects are not duplicative.

Provision of navigation services is linked to multiple other regional DSRIP initiatives: 1) integration of primary and specialty care/care transitions through communication of screening results to primary care and by linking women with specialty diagnostic and treatment services, 2) standardized navigation pathways and practices promote consistent care delivery models, and 3) enhance

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[130] Hewitt M, Simone JV, editors. Ensuring Quality Cancer Care. Washington, DC: National Academies Press; 1999.

[131] Barbera L, Paszat L, Chartier C. Indicators of poor quality end-of-life cancer care in Ontario. J Palliat Care. 2006;22:12–17. [PubMed]
[132] Med Sci Monit. 2006 Jul;12(7):CR319-24. Epub 2006 Jun 28.

[133] Clin Oncol. 2011 July 1; 29(19): 2683–2688.

culturally competent care – materials are available in multiple languages and screening team members speak Spanish as well as English.

137265806.2.2 – Women's Oncology Care Screening
137265806.1.4 – Language Services Resource Center
137265806.1.5 – Culturally Competent Care Training

List of Related Category 4 Projects
RD-4: PatientCentered Healthcare RD-1: Potentially Preventable Admissions
RD-2: 30-day Readmissions

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

Projects proposed by other providers across the Region also relate to improved management of chronic conditions, including cancer.

307459301.1.1 – Disease Management Registry
307459301.2.1– Patient-Centered Medical Home Project
307459301.2.2 – Expand Chronic Care Management Models

The performing provider will fully participate in a RHP-wide learning collaborative for projects which directly address improving healthcare services to all patients and all projects providing navigation services to patients. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference, or electronically.

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol. This project will result in better health outcomes, increased patient satisfaction, appropriate utilization of services and reduced cost of services.

UNIQUE IDENTIFIER: 137265806.2.8 – PASS 3	RHP PP REFERENCE NUMBER 2.9.1	PROJECT COMPONENTS: 2.9.1 (A-E)	PROJECT TITLE: PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: EXPAND WOMEN'S ONCOLOGY NAVIGATION PROGRAM	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.16 – Pass 3*	*IT-6.1*	*Patient percent improvement over baseline of patient satisfaction scores*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric [P-1.1]: Provide report identifying the following: a. Targeted patient population characteristics b. Gaps in services and service needs. c. How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). d. Ideal number of patients targeted for enrollment in the patient navigation program e. Number of Patient Navigators needed to be hired f. Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients Goal: Produce a report covering all points above based on available data. Data Source: Program documentation	**Milestone 5** [I-X]: Provide navigation services to targeted patients. Metric 1 [I-X.1]: Increase in the number of patients enrolled in the Patient Navigation Program. Baseline - At beginning of DY2, baseline is 0. Goal – Enroll 1971 patients in the program. Data Source: Enrollment records Milestone 5 Estimated Incentive Payment: $613,604 **Milestone 6:** [P-8] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-8.1] Participate in semi-annual face-to-face meetings or		**Milestone 7** [I-X]: Provide navigation services to targeted patients. Metric 1 [I-X.1]: Increase in the number of patients enrolled in the Patient Navigation Program. Baseline - At beginning of DY2, baseline is 0. Goal – Enroll 2528 patients in the program. Data Source: Enrollment records Milestone 7 Estimated Incentive Payment: $614,437 **Milestone 8:** [P-8] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-8.1] Participate in semi-annual face-to-face meetings or	**Milestone 9** [I-X]: Provide navigation services to targeted patients. Metric 1 [I-X.1]: Increase in the number of patients enrolled in the Patient Navigation Program. Baseline - At beginning of DY2, baseline is 0. Goal – Enroll 3312 patients in the program. Data Source: Enrollment records Milestone 9 Estimated Incentive Payment: $507,929 **Milestone 10:** [P-8] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-8.1] Participate in semi-

UNIQUE IDENTIFIER: 137265806.2.8 – PASS 3	RHP PP REFERENCE NUMBER 2.9.1	PROJECT COMPONENTS: 2.9.1 (A-E)	PROJECT TITLE: PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: EXPAND WOMEN'S ONCOLOGY NAVIGATION PROGRAM	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.16 – Pass 3*	*IT-6.1*	*Patient 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 Estimated Incentive Payment: $329,866 **Milestone 2** [P-2]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline: At the beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Goal: Two continuous education sessions for patient navigators completed. Data Source: Training documentation. Milestone 2 Estimated Incentive Payment: $329,866	seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $ 613,603		seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 614,437	annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 10 Estimated Incentive Payment: $507,928

UNIQUE IDENTIFIER: 137265806.2.8 – PASS 3	RHP PP REFERENCE NUMBER 2.9.1	PROJECT COMPONENTS: 2.9.1 (A-E)	PROJECT TITLE: PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: EXPAND WOMEN'S ONCOLOGY NAVIGATION PROGRAM	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.16 – Pass 3*	*IT-6.1*	*Patient percent improvement over baseline of patient satisfaction scores*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Milestone 3 [I-X]: Provide navigation services to targeted patients. Metric 1 [I-X.1]: Increase in the number of patients enrolled in the Patient Navigation Program. Baseline - At beginning of DY2, baseline is 0. Goal – Enroll 1479 patients in the program. Data Source: Enrollment records. Milestone 3 Estimated Incentive Payment: $329,865 _____ **Milestone 4 :** [P-8] Participate in face-to-face learnings at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly comments to implementing these improvements. Metric [P-8.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-				

UNIQUE IDENTIFIER: 137265806.2.8 – PASS 3	RHP PP REFERENCE NUMBER 2.9.1	PROJECT COMPONENTS: 2.9.1 (A-E)	PROJECT TITLE: PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: EXPAND WOMEN'S ONCOLOGY NAVIGATION PROGRAM	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI - 137265806*
Related Category 3 Outcome Measure:	*137265806.3.16 – Pass 3*	*IT-6.1*	*Patient 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)
face learning at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $329,865				
Year 2 Estimated Milestone Bundle Amount: $ 1,319,462	**Year 3 Estimated Milestone Bundle Amount: $ 1,227,207**		**Year 4 Estimated Milestone Bundle Amount: $1,228,874**	**Year 5 Estimated Milestone Bundle Amount: $ 1,015,857**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $ 4,611,400				

UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE (UMCB)
Diabetes Chronic Care Management
PROJECT ID: 137265806.2.9 – PASS 3

Provider: UMCB is a 399-bed acute-care hospital located in Austin (pop. 820,000), Travis County (pop. 1.1 million), Texas and is known as the region's largest safety net provider. It operates several community clinics to serve the indigent and is the 4th busiest emergency department in the State. UMCB is operated by Seton Family of Hospitals. Through Seton, UMCB patients have access to primary and specialty care services, a psychiatric hospital, a rehabilitation hospital and a dedicated children's hospital.
Intervention(s): This project incorporates performance improvement methodologies and evidence-based interventions to decrease 30-day readmissions for adult diabetics. Interdisciplinary care will be delivered based on standardized inpatient protocols that can reduce potentially preventable complications and develop discharge management guidelines to maximize the patient's ability to self-manage their disease upon discharge and reduce the likelihood of preventable readmissions.

Need for the project: A more efficient and effective Interdisciplinary Diabetes Team will lead to reductions in 30 day admission rates. Redesign of the delivery system through this project should optimize a patient's transition from inpatient care to outpatient and self-care, ultimately reducing readmissions, adverse medical events, and even mortality. This addresses CN.9 of the RHP Plan.

Target population: Adult inpatients at UMCB and two other Seton-operated hospitals in Travis County who are either at risk for diabetes, or diagnosed with diabetes, and who are at risk for readmission.

Category 1 or 2 expected patient benefits: [I-X.1] The number of inpatients to receive the new standardized protocol (in-hospital diabetes testing and education, followed by a discharge plan communicated to a follow-up care provider) is as follows: 500 in DY2, 2,800 in DY3, 3,000 in DY4, and 3,200 in DY5. Total patients receiving protocol: 9,500 (DY2-DY5). [IT-13] During the life of this project (DY2-DY5) 17,100 inpatients will receive a HbA1c test and diabetes education during their hospitalization and an individualized discharge care plan communicated to their follow-up healthcare provider

Category 3 outcomes: [IT-3.3] Decrease by 3% in DY4 and by 5% in DY5, the baseline 30-day readmission rate for program participants.

Title of Project: **Reduction in 30 Day Hospital Readmission Rates: Adult diabetes inpatient chronic care management**

Category / Project Area / Project Option: **2.8.4**

RHP Project Identification Number: **137265806.2.9 – Pass 3**

Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Project Description:

UMCB proposes to develop and implement a process improvement methodology to improve outcomes and reduce hospital readmission rates for adult inpatient diagnosed with Diabetics Mellitus.

This project implements small, straightforward evidenced-based practices to implement a *Diabetes Care Bundle*, that when performed collectively and reliably have been proven to improve patient outcomes. By setting the standard of inpatient disease care to provide earlier diagnostic testing (HbA1c), better blood glucose control, increased access to diabetes education, and post hospital diabetes management we will reduce variation of care and expect to patient outcomes and reduce readmission rates. The *Diabetic Care Bundle* will be delivered by an interdisciplinary team to inpatients at UMCB and two other Seton hospitals[134] who have been diagnosed with Diabetes Mellitus.

The project will implement the *Diabetes Care Bundle* early during the patient's hospitalization. In particular, HbA1c tests will be performed for any patients identified with diabetes early in their hospital stay. This will identify patients subject to complications during hospitalization and help anticipate diabetes home regimen and self-care management. Professional Certified Diabetes Educators will assess and identify patient preferences and limitations related to diabetes self-management, including co-morbidities to mitigate post discharge barriers.

During the hospitalization, the team will work collaboratively with the admitting physicians of patients with Diabetes Mellitus. The team will be led by a Physician Endocrinologist and Diabetes Clinical Nurse Specialist and will consist of diabetes experts including Certified Diabetes Educators, Advanced Practice Nurses, Registered Dietitians, Diabetes Resource Nurses, Care Navigators, Case Managers, LMSW, Clinical Assistants, Diabetes Resource Nurses, other healthcare clinicians, and supportive staff.

The team will implement evidence-based protocols in alignment with the American Diabetes Association Clinical Practice Guidelines, The Endocrine Society Clinical Practice Guidelines, and the American Association of Diabetes Educators.[135] These provider process improvements measures will be implemented through staff training classes lead by Certified Diabetes Educators, checklists and other provider tools. The team will also manage post-discharge communication with the follow-up healthcare providers to alert them of the patient's hospitalization and discharge regimen. Follow-up contact with the patient will occur within 72 hours.

Goals and Relationship to Regional Goals:

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[134] Seton Medical Center Austin and Seton Northwest Hospital.

[135] American Diabetes Association. Standards of medical care in diabetes – 2013. Diabetes Care. 2013; 36(supp 1): S11-S66; Diabetes Care January 2013 vol. 36 no. Supplement 1 S11-S66; http://care.diabetesjournals.org/content/36/Supplement1/S11.full; https://www.aace.com/files/dm-guidelines-ccp.pdf

The goal of this project is to use the Interdisciplinary Diabetes Team to provide excellence in care for patients with diabetes. The team will ensure that patients are evaluated and given a customized tools for managing their disease post-discharge. A more efficient and effective Interdisciplinary Diabetes Team will lead to reductions in 30 day admission rates. In turn, the initiative promotes patient, provider and staff satisfaction while providing patient centered care by improving the patient's experience, quality of care and education.

Project Goals:

- Develop and implement standardized, evidenced-based care protocols
- Develop and train staff in the implementation of the *Diabetes Care Bundle*
- Monitor the effectiveness of this process improvement
- Identify patients at risk for diabetes related complications
- Identify diabetic patients at risk of re-admission
- Assess barriers to successful disease management and provide tools for overcoming the obstacles
- Reduce 30 day readmissions for the population served.

This project meets the following regional goals:

- Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. (RHP Goal #2)
- Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. (RHP Goal #3)
- Improve the patient experience of care by increasing the quality of care and patient safety. (RHP Goal #7)

This project expands opportunities for patients and families to access more appropriate care through education that allows them to overcome barriers to disease management. It improves patient experience by addressing the patient's needs directly with patients and families, enabling them to avoid future admissions. Quality of care is improved through knowledge of and management of diabetes while the patient is in the hospital.

Challenges:

Changing the current culture within the health system in regards to diabetes care is a major challenge of this project. Currently, there is no standard implementation of evidence-based care protocols for inpatients diagnosed with diabetes. Further, short hospital stays have the use of HbA1c testing during hospitalization, making it difficult to anticipate the home regimen needed and provide solutions to barriers in patient self-care.

These challenges will be addressed through post-discharge planning that includes communication and coordination with follow-up healthcare providers, along with training nursing staff regarding the *Diabetes Care Bundle* and need for HbA1c testing to ensure the best care. Further, a patient's ability to receive education in blocks of time throughout hospitalization by different healthcare professionals, i.e. nursing staff, diabetes educator, dieticians and case manager, will lead to increased retention of skills and knowledge, resulting in enhanced self-care in the long term. Dedicated Certified Diabetes Educators, assessing patient motivation and readiness to accept the challenges of

a new diagnosis of diabetes, or self-care for a long-standing diagnosis, will provide information and training to maximize the chances of successful self-management post-discharge.

5-Year Expected Outcome for Provider and Patients:
We expect to see an improvement in inpatient diabetes management through the use of standardized protocols and staff training. This will increase the number of patients receiving an HbA1c test and diabetes education during their stay and provide them with an individualized diabetes care management plan upon discharge. The provider expects to see a reduction in 30-day readmission rates for participating patients.

Starting Point/Baseline:
Currently, UMCB refers all to opportunities for outpatient care and education; there is no similar inpatient program. This is a new program; baseline is zero.

Rationale:
According to the American Diabetes Association, diabetes affects 1 in 3 hospitalized patients[136]. Texas demographers project a 259% increase in the number of adults with diabetes from 2010 to 2040, with staggering projections of a 220% increase in Travis County, and 665%-754% increases in neighboring Williamson and Hays counties, respectively[137]. To prepare for the projected dramatic increase in the volume of people with diabetes, health care provider need to both develop additional infrastructure and redesign the delivery of care.

DSRIP funding as the result of the 1115 Waiver provides UMCB with the opportunity to redesign the provision of care to diabetic patients, using evidence-based protocols developed by the American Diabetes Association, the Endocrine Society, and the American Association of Diabetes Educators.

Redesign of the delivery system through this project should optimize a patient's transition from inpatient care to outpatient and self-care, ultimately reducing readmissions, adverse medical events, and even mortality. Without sufficient information and an understanding of their condition, medication and self-care needs, patients cannot fully participate in their care during admission and post-discharge. Reworking the discharge planning process will improve communication, reduce the likelihood of potentially preventable complications, and equip the patient with knowledge and skills to self-manage their diabetes.

People living with diabetes struggle to live with the complexity of their medical condition and often co-morbidities such as neuropathy and heart disease are often present at time of the diagnosis. 1 in 3 people with diabetes are diagnosed with depression which compounds the challenges of living a healthy life with diabetes. By having a comprehensive program that delivers the best possible care including licensed social worker that will address the behavioral and psychosocial aspects of

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[136] American Diabetes Care, Vol. 30, Supplement 1, January 2007

[137] http://texascure.org/learn/diseases-and-injuries/diabetes-texas; http://www.tmf.org; http://www.texasheatlhinstitute.org

diabetes, communicate this to the team, allowing these barriers to be addressed before discharge, and improve outcomes for the patient at discharge and through the continuum of care.

Project Components:
The only required component for this intervention is quality improvement initiatives. UMCB intends to participate in learning collaboratives within the region, as discussed below. Further, the project will consist of several components:

- Staff training for implementation of this process improvement measure.
- HbA1c testing for all at-risk patients
- Discharge checklists for nursing staff will be developed to ensure that all necessary instructions have been delivered
- "Hand-off" communication plans with follow-up providers will be developed and implemented
- Self-care training for patients and families with high risk of readmission by the Interdisciplinary Diabetes Team
- Early follow up with patient within 72 hours of discharge to ask whether they are compliant with the discharge instructions and have been in contact with a follow-up provider

Unique community need identification numbers the project addresses:
- CN.8 - High rates of non-emergent emergency department usage and potentially preventable inpatient admissions
- CN.9 - High rates of chronic disease such as:
    - Cardiovascular disease
    - Cancer
    - Rising rates of diabetes
- CN.10 - Many residents in Region 7 have multiple chronic conditions
- CN.11 - Rising rates of physical inactivity and obesity

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The current Adult Inpatient Diabetes Team only provides inpatients with referrals to outpatient diabetes education, with no opportunity for communicating the discharge regimen or HbA1c test results to the follow-up care provider. This project will address patients' needs while they are in the hospital, as well as prepare and communicate discharge plans to the follow-up healthcare provider for helping to manage the disease post-discharge. It also provides education to inpatients at a time when they are most likely to be receptive.

Related Activities Funded by U.S. Dept. of Health and Human Services.
This project complements, but does not duplicate other current initiatives funded by the US Department of HHS, either directly or indirectly or through state initiatives.

Related Category 3 Outcome Measures:
OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
IT-3.3 Diabetes 30-day readmission rate

Reasons/rationale for selecting the outcome measures:
Hospitals are providing care for an increasing number of patients diagnosed with diabetes. Often, these patients enter the healthcare system with a serious complication of diabetes such as a heart attack, without knowing that the underlying cause was undiagnosed diabetes. Further, even with knowledge of the condition, many diabetics enter the hospital because of a lack of care or training regarding self-management. These patients rely on the services of the experts in the hospital to help them understand their disease and understand their medication regime and assist with discharge planning and follow-up health care.

In a system that is already struggling with the resources to provide all of the needed inpatient services, it is difficult to find resources to also provide education and post-discharge planning. As a result, many diabetes patients are readmitted to the hospital for reasons such as non-adherence to medications, financial difficulties with medical care costs, and a lack of understanding of discharge care plan and lack of follow-up with a healthcare provider. The interdisciplinary model works towards effectively enhancing this system and its primary goal is to decrease the diabetes 30-day readmission rates by implementing process improvements to the system and across the continuum of care.

Relationship to other Projects:
There are several projects within UMCB that will supplement and support our proposal for an interdisciplinary Diabetes Care team. Although these projects are related, they each represent different points along the continuum of chronic disease care and, therefore, are not duplicative.

137265806.2.5 – Care Transitions
137265806.2.6 - Chronic Care Management: Adults
137265806.1.4 - Language Services Resource Center
137265806.1.5 - Culturally Competent Care Training

List of Related Category 4 Projects *(RHP Project ID Number)*
RD-2: Diabetes 30-Day Readmission
RD-2: All-Cause 30-Day Readmission
RD-3: Potentially Preventable Complications
RD-4: Patient Satisfaction

Projects proposed by other providers across the Region also relate to Chronic Care Management. These projects serve different populations.

201320202.2.2 – Expansion of Community Diabetes Project
186599001.2.2 – Chronic Care Management – Pediatrics
133542405.2.5 - Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults
307459301.2.1 - Patient-Centered Medical Home Project
307459301.1.1 - Implement/enhance and use chronic disease management registry functionalities
307459301.2.2 - Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions

307459301.1.5 - Expanded Specialty Care Services at Community-Based Outpatient Settings: Musculoskeletal
307459301.2.3 - Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
The performing provider will fully participate in RHP-wide learning collaboratives for projects that directly address care transitions and chronic disease management. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas, and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically. In this instance, the providers include:

City of Austin Health and Human Services Department – 201320202
Central Texas Medical Center – 121789503
Dell Children's Medical Center– 186599001

Project Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE IDENTIFIER: 137265806.2.9 – PASS 3	***RHP PP REFERENCE NUMBER: 2.8.4***	***PROJECT COMPONENTS: NONE***	***PROJECT TITLE: REDUCTION IN 30 DAY HOSPITAL READMISSION RATES: ADULT DIABETES INPATIENT CHRONIC CARE MANAGEMENT***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI -137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.17 – PASS 3*	*IT-3.3*	*Potentially Preventable Re-admissions – 30 day Readmission Rates (PPRs)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Define operational procedures needed to improve overall efficiencies in care management. Metric [P-4.1]: Report on at least two new operational procedures needed to improve overall efficiencies in care management. Goal: Submission of analysis findings/summary Data Source: Program report **Milestone 1 Estimated Incentive Payment: $ 449,688** **Milestone 2** [P-X]: Tools for consistent delivery of care Metric [P-X.1]: Develop standardized Diabetes Care Bundle for nursing staff use. Baselines/Goal: Standardized Diabetes Care Bundle Data Source: Program materials; Training documents	**Milestone 7** [I-13]: Progress toward target/goal Metric [I-13.1]: Number or percent of all clinical cases that meet target/goal Baseline: This a new project; baseline at DY2 is zero. Goal: 4,200 inpatients with diabetes will have a HbA1c test performed during hospitalization. Data Source: Patientmedical records; Laboratory reports**Milestone 7 Estimated Incentive Payment: $ - 726,474** **Milestone 8** [I-X] Increase the number of patients in defined population receiving standardized care according to the program's protocols and policies. Metric [I-X.1]: Number of inpatients whose HbA1c testing result and discharge care plan is communicated to their follow-up healthcare provider Baseline: This a new project; baseline at		**Milestone 11** [I-13]: Progress toward target/goal Metric [I-13.1]: Number or percent of all clinical cases that meet target/goal Baseline: This a new project; baseline at DY2 is zero. Goal: 4,400inpatients with diabetes will have a HbA1c test performed during hospitalization. Data Source: Patientmedical records; Laboratory reports**Milestone 11 Estimated Incentive Payment: $ 727,464** **Milestone 12** [I-X] Increase the number of patients in defined population receiving standardized care according to the program's protocols and policies. Metric [I-X.1]: Number of inpatients whose HbA1c testing result and discharge care plan is communicated to patient's follow-up care provider. Baseline: This a new project; baseline at DY2 is zero	**Milestone 15** [I-13]: Progress toward target/goal Metric [I-13.1]: Number or percent of all clinical cases that meet target/goal Baseline: This a new project; baseline at DY2 is zero. Goal: ,500inpatients with diabetes will have a HbA1c test performed during hospitalization. Data Source**:** Patientmedical records; Laboratory reports**Milestone 15 Estimated Incentive Payment: $ 801,818** **Milestone 16** [I-X] Increase the number of patients in defined population receiving standardized care according to the program's protocols and policies. Metric [I-X.1]: Number of inpatients whose HbA1c testing result and patient's care plan is provided to patient's follow-up healthcare provider. Goal: 3,200 inpatients will have their

UNIQUE IDENTIFIER: 137265806.2.9 – PASS 3	***RHP PP REFERENCE NUMBER: 2.8.4***	***PROJECT COMPONENTS: NONE***	***PROJECT TITLE: REDUCTION IN 30 DAY HOSPITAL READMISSION RATES: ADULT DIABETES INPATIENT CHRONIC CARE MANAGEMENT***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI -137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.17 – PASS 3*	*IT-3.3*	*Potentially Preventable Re-admissions – 30 day Readmission Rates (PPRs)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 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:$449,688 **Milestone 3** [P-11]: Number of trainings conducted by designated trainee/process improvement champions Metric [P-11.1] Training conducted by the trainee/champion Baseline: This is a new program; baseline at DY2 is zero. Goal: The process improvement champion will train 300 nurses in the designated process improvement, the *Seton Diabetes Care Bundle* Data Source: Training materials; training attendance records. **Milestone 3 Estimated Incentive Payment:$449,688** **Milestone 4** [I-13]: Progress toward target/goal	DY2 is zero Goal: 2,800 inpatients will have their HbA1c testing result and discharge care plan is communicated to their follow-up healthcare provider Data Source: Medical records; program logs and reports **Milestone 8 Estimated Incentive Payment: $ 726,474** **Milestone 9** [P-11]: Number of trainings conducted by designated trainee/process improvement champions Metric [P-11.1] Training conducted by the trainee/champion Goal: The process improvement champion will train 500 nurses in the designated process improvement, the *Seton Diabetes Care Bundle* Data Source: Training materials; training attendance records		Goal: 3,000 inpatients will have their HbA1c testing results and discharge care plan communicated to their follow-up healthcare provider Data Source: Medical records; program administrative logs; **Milestone 12 Estimated Incentive Payment: $ 727,464** **Milestone 13** [P-11]: Number of trainings conducted by designated trainee/process improvement champions Metric [P-11.1] Training conducted by trainee/champion trainings Baseline: This is a new program; baseline at DY2 is zero. Goal: The process improvement will train 300 nurses in the designated process improvement; the *Seton Diabetes Care Bundle* Data Source: Training materials;	HbA1c testing results and discharge care plan provided to their follow-up healthcare provider Data Source: Medical records; program administrative logs; **Milestone 16 Estimated Incentive Payment: $ 808,818** **Milestone 17** [P-15]**:** Participate in face-to-face learning (i.e. meetings/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 [P-15.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-

UNIQUE IDENTIFIER: 137265806.2.9 – PASS 3	***RHP PP REFERENCE NUMBER: 2.8.4***	***PROJECT COMPONENTS: NONE***	***PROJECT TITLE: REDUCTION IN 30 DAY HOSPITAL READMISSION RATES: ADULT DIABETES INPATIENT CHRONIC CARE MANAGEMENT***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI -137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.17 – PASS 3*	*IT-3.3*	*Potentially Preventable Re-admissions – 30 day Readmission Rates (PPRs)*	
Year 2 (10/1/2012 – 9/30/2013)	**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 [I-13.1]: Number or percent of all clinical cases that meet target/goal Baseline: This a new project; baseline at DY2 is zero. Goal: 4,000 inpatients with diabetes will have a HbA1c test performed during hospitalization. Data Source**:**Patientmedical records; Laboratory reports**Milestone 4 Estimated Incentive Payment: $ 449,688** **Milestone 5** [I-X] Increase the number of patients in defined population receiving standardized care according to the program's protocols and policies. Metric [I-X.1]: Number of inpatients whose HbA1c testing results and discharge care plan is communicated to patient's follow-up healthcare provider. Baseline: This a new project; baseline at DY2 is zero Goal: 500 inpatients will have their	**Milestone 9 Estimated Incentive Payment:$726,474** **Milestone 10** [P-15]**:** Participate in face-to-face learning (i.e. meetings/seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric [P-15.1]:Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings twice a year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.		training sessions attendance records. **Milestone 13 Estimated Incentive Payment:$ 727,463** **Milestone 14** [P-15]: Participate in face-to-face learning (i.e. meetings/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 [P-15.1]:Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-face learnings twice a year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations,	face learnings twice a year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 17 Estimated Incentive Payment: $ 801,817**

UNIQUE IDENTIFIER: 137265806.2.9 – PASS 3	***RHP PP REFERENCE NUMBER: 2.8.4***	***PROJECT COMPONENTS: NONE***	***PROJECT TITLE: REDUCTION IN 30 DAY HOSPITAL READMISSION RATES: ADULT DIABETES INPATIENT CHRONIC CARE MANAGEMENT***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI -137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.17 – PASS 3*	*IT-3.3*	*Potentially Preventable Re-admissions – 30 day Readmission Rates (PPRs)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
HbA1c testing result and discharge care plan is communicated to their follow-up healthcare provider. Data Source: Patient medical records; program logs and reports **Milestone 5 Estimated Incentive Payment*: $ 449,688*** **Milestone 6** [P-15]**:** Participate in face-to-face learning (i.e. meetings/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 [P-15.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in face-to-	**Milestone 10 Estimated Incentive Payment*: $ 726,474***		and/or meeting notes. **Milestone 14 Estimated Incentive Payment:$ 727,463**	

UNIQUE IDENTIFIER: 137265806.2.9 – PASS 3	***RHP PP REFERENCE NUMBER: 2.8.4***	***PROJECT COMPONENTS: NONE***	***PROJECT TITLE: REDUCTION IN 30 DAY HOSPITAL READMISSION RATES: ADULT DIABETES INPATIENT CHRONIC CARE MANAGEMENT***	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)				*TPI -137265806*
Related Category 3 Outcome Measure(s):	*137265806.3.17 – PASS 3*	*IT-3.3*	*Potentially Preventable Re-admissions – 30 day Readmission Rates (PPRs)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
face learnings twice a year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 6 Estimated Incentive Payment*:* $ 449,687**				
Year 2 Estimated Milestone Bundle Amount: $2,698,127	**Year 3 Estimated Milestone Bundle Amount: $2,905,896**		**Year 4 Estimated Milestone Bundle Amount: $ 2,909,854**	**Year 5 Estimated Milestone Bundle Amount: $ 2,405,453**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $ 10,919,330				

Austin Travis County Integral Care (ATCIC)
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): **IT-9.2: Reduce Emergency Department Visits for Behavioral Health Conditions**
Unique RHP Outcome Identification Number: **133542405.3.4 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Outcome Measure Description

Overall Outcome Measure Description

OD-9 Right care, Right Setting
Milestone IT-9.2: **Reduce Emergency Department Visits for Behavioral Health Conditions**

a. Numerator: The number of Emergency Department (ED) visits by individuals who present for their behavioral health condition after visiting a primary care setting in the previous three to six months
b. Denominator: The total number of individuals visiting primary care settings in a 12 month period

Process Milestones for Each Year
DY 2: P-1: Project Planning
Metric: Project report and implementation plan
Data Source: Project report and implementation plan

DY 3: P-2: Establish Baseline Rates
Metric 1: Determine number of patients visiting Emergency Departments for Behavioral Health Conditions that had been seen in a primary care setting in the previous three to six months. Data Source: Hospital ED and primary care database

DY 4: N/A

DY 5: N/A

Outcome Improvement Targets for Each Year:
DY 2: N/A

DY 3: N/A

DY 4: IT-9.2: Reduction in Emergency Department Visits for Behavioral Health Conditions. Target is 5 percent decrease below baseline for individuals seen in primary care settings in the previous 3 to 6 months.

DY 5: IT-9.2 Reduction in Emergency Department Visits for Behavioral Health Conditions. Target is 10 percent decrease below baseline for individuals seen in primary care settings in the previous 3 to 6 months.

Related Category 1 Unique RHP Project Identifier: *133542405.1.1*

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

For DY2, process milestone P-1 was selected to ensure adequate time will be invested in project planning and finalization of project implementation. A focused, collaborative project planning process will provide opportunity to build this collaboration and partner with primary care settings in a deliberate and thoughtful planning process. For DY3, process milestone P-2 was chosen to allow opportunity to establish baseline numbers and ensure appropriate planning in anticipation of achieving improvement targets during DY4 and DY5. For DY4 and DY5, ATCIC selected improvement milestone IT-9.2, Reduction in Emergency Department Visits for Behavioral Health Conditions, with a five percent decrease below baseline target for individuals seen in primary care settings in the previous three to six months. In DY5, the target is 10 percent decrease below baseline for individuals seen in primary care settings in the previous three to six months.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The improvement targets will be determined in DY3.

Briefly describe how the related Category 2 projects will achieve this outcome measure.

This project addresses the challenge of systematically identifying, enrolling and training primary care staff in evidence-based trainings in mental health and suicide prevention. These programs specialize in best practices that will improve staff's knowledge, skill and confidence in managing their patients with mental health problems and suicidal risk. Trained staff will be able to identify and refer patients to more appropriate care so they don't turn to emergency departments to meet their behavioral healthcare needs. Research shows that patients are more likely to seek appropriate behavioral healthcare if their physician makes the recommendation. Staff will link patients to behavioral health services within the integrated primary care setting, to expanded outpatient services, and when necessary, mobile crisis outreach services or psychiatric emergency services.

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure -

The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and cost reduction to the healthcare system. In considering the incentive portion of the valuation, three principles and their subsequent impacts were considered. These principles include: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. By training primary care staff to identify, treat, or refer patients to appropriate specialty behavioral healthcare, patients are less likely to use ED's for their psychiatric needs.

Calculating the value of interventions for this project for a specialty behavioral health population was done using an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often frequent users of the healthcare system. These individuals also frequently present with a number of functional impairments, which lead to involvement in the criminal justice system. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare and criminal justice systems.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.4	3.IT-9.2	9.2 Reduce Emergency Department Visits for Behavioral Health Conditions	
Austin Travis County Integral Care			***133542405***
Related Category 1 or 2 Projects:	***133542405.1.1***		
Starting Point/Baseline:	Baseline will 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 P-1: Project Planning Metric 1P-1.1: Project plan Baseline/Goal: Completed plan Data Source: Project documentation Process Milestone 1 Estimated Incentive Payment: $23,494	**Process Milestone** P-2: Establish Baseline Rate Metric P-2.1: Determine number of patients visiting EDs for behavioral health conditions that had previously been seen in the primary care setting Baseline/Goal: Determine Baseline Data Source: Hospital ED and primary care database Process Milestone 2 Estimated Incentive Payment: $54,465	**Outcome Improvement Target 1** [IT-6.2]: Reduce Emergency Department Visits for Behavioral Health Conditions Improvement Target: 5% reduction in ED visits for patients previously seen in the primary care setting Data Source: Hospital ED and primary care database Outcome Improvement Target 1 Estimated Incentive Payment: $58,265	**Outcome Improvement Target 2** [IT-6.2]: Reduce Emergency Department Visits for Behavioral Health Conditions Improvement Target: 10% reduction in ED visits for patients previously seen in the primary care setting Data Source: Hospital ED and primary care database Outcome Improvement Target 1 Estimated Incentive Payment: $126,663
Year 2 Estimated Outcome Amount: $23,494	Year 3 Estimated Outcome Amount: $54,465	Year 4 Estimated Outcome Amount: $58,265	Year 5 Estimated Outcome Amount: $126,663
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $262,887			

Title of Outcome Measure: **IT-1.18: Follow-up After Hospitalization for Mental Illness**

Unique RHP Outcome Identification Number): **133542405.3.5 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Outcome Measure Description

Overall Outcome Measure Description

IT-1.18: Follow-up After Hospitalization for Mental Illness
IT-1.18: Rate 1 – Follow-up visit 30-days after discharge with a mental health practitioner;
Rate 2 – Follow-up visit 7-days after discharge with a mental health practitioner

Process Milestones for Each Year

DY 2: P-2: Establish Baseline Rates
Metric: Number enrolled in services, receiving f/u within specified time frames

DY 3: N/A
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: 5 percent over baseline established in DY 2
DY 4: 10 percent improvement over baseline
DY 5: 15 percent improvement over baseline

Related Category 1 and Category 2 Unique RHP Project Identifiers: 133542405.1.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

In DY 2 process measure P-2 was selected to ensure accurate baseline rates are established for the seven and 30-day follow-up post psychiatric hospitalization for mental illness. Improvement targets over the baseline established in DY 2 are expected to be five percent over baseline in DY 3, 10 percent in DY 4 and 15 percent in DY 5.

The CNA for RHP-7 reveals that Travis County experienced a 33 percent increase in inpatient hospitalizations from 2008 to 2010. Further, Travis County, suicides are the eighth leading cause of death and the fourth leading preventable cause of death. Research indicates that the weeks after discharge represent a critical period for suicide risk (Hunt et al. Psychological Medicine (2009). 39, 443-449).

The addition four psychiatric prescribers at ATCIC's two outpatient clinics and PES will assist people to receive timely follow-up care post psychiatric hospitalization.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
Baseline will be established in DY 2

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The anticipated outcome of this project is to increase access and capacity to provide behavioral health prescribers serving the safety-net population at four outpatient clinic settings in Travis County. Four psychiatric providers will be located at key service points that treat safety net population. Two prescribers will provide services at ATCIC's two outpatient clinics serving adults with SMI. A third prescriber will provide services at PES to individuals experiencing a psychiatric crisis. The fourth prescriber will be located at CommUnityCare's healthcare for the homeless clinic to provide this vital service to the most vulnerable population in our community.

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure
The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. These psychiatric providers will be deployed to ATCIC's Psychiatric Emergency Services site, at a primary care clinic site provided healthcare individuals who are homeless through CommUnityCare , and at ATCIC's two adult outpatient clinic sites.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.5	3.IT-1.18	IT- 1.18 Follow-up After Hospitalization for Mental Illness	
Austin Travis County Integral Care			133542405
Related Category 1 or 2 Projects:	133542405.1.2		
Starting Point/Baseline:	Baseline to be Established in Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish Baseline Rates Metric - Number enrolled in services, receiving f/u within specified time frames Goal: Establish Baseline Data Source: EHR & project data Process Milestone 1 Estimated Incentive Payment*:* $127,755	**Outcome Improvement Target 1** [IT-1.18]: Follow-up After Hospitalization for Mental Illness Metric: IT-1.18: Rate 1 - Follow-up visit 30-days after discharge; Rate 2 – F/U 7-days after discharge Improvement Target: 5% improvement over DY-2 baseline Data Source: EHR & project data Outcome Improvement Target 1 Estimated Incentive Payment*:* $296,171	**Outcome Improvement Target 2** [IT-1.18]: Follow-up After Hospitalization for Mental Illness Metric: IT-1.18: Rate 1 - Follow-up visit 30-days after discharge; Rate 2 – F/U 7-days after discharge Improvement Target: 10% improvement over DY-2 baseline Data Source: EHR & project data Outcome Improvement Target 2 Estimated Incentive Payment*:* $316,824	**Outcome Improvement Target 3** [IT-1.18]: Follow-up After Hospitalization for Mental Illness Metric: IT-1.18: Rate 1 - Follow-up visit 30-days after discharge; Rate 2 – F/U 7-days after discharge Improvement Target: 15% improvement over DY-2 baseline Data Source: EHR & project data Outcome Improvement Target 3 Estimated Incentive Payment*:* $688,760
Year 2 Estimated Outcome Amount: $127,755	Year 3 Estimated Outcome Amount: $296,171	Year 4 Estimated Outcome Amount: $316,824	Year 5 Estimated Outcome Amount: $688,760
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,429,510			

Title of Outcome Measure: **IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores**

Unique RHP Outcome Identification Number: **133542405.3.6 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Outcome Measure Description

Overall Outcome Measure Description
IT-6.1: Percent Improvement in Satisfaction over baseline of patient satisfaction scores – Patients are getting timely care, appointments and information

Process Milestones for Each Year
DY 2: Establish Baseline Satisfaction Scores on Press-Ganey Survey
DY 3: N/A
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:
DY 2: N/A
DY 3: 5 percent improvement over baseline
DY 4: 10 percent improvement over baseline
DY 5: 15 percent improvement over baseline

Related Category 1 and Category 2 Unique RHP Project Identifiers: 133542405.1.3

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
Process milestone P-2 and improvement target IT-6.1 to ensure that a meaningful baseline for patient satisfaction scores related to this new service is established. Improvement targets over the next three years will assist in determining how this new service is meeting patient access needs.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
Baseline for improvement targets will be established in DY 2

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The goal of this project is to increase access and capacity to psychiatric assessments and medication services for the safety-net population in Travis County through deployment of psychiatric telemedicine services at three ATCIC outpatient clinic sites. The PES clinic will have psychiatric telemedicine services accessible after hours Monday through Friday and 24-hours per day on Saturday and Sunday. ATCIC's two outpatient clinics, Psychiatric and Counseling Services and the North Services Center, will also use telemedicine services for individuals needing immediate evaluation and/or medication management services to ensure the right care at the right time and in the right setting. The goal throughout four years is

to increase the number of adult consumers who access psychiatric telemedicine services by five percent in DSRIP DY 3, 10 percent in DY 4 and 15 percent in DY 5 over baseline.

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure

The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. This psychiatric telemedicine service will be deployed to ATCIC's Psychiatric Emergency Services site and at ATCIC's two adult outpatient clinic sites.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.6	IT-6.1	Percent Improvement in Patient Satisfaction Scores over Baseline	
Austin Travis County Integral Care			133542405
Related Category 1 or 2 Projects:	133542405.1.3		
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-2] Determine baseline satisfaction survey scores for individuals enrolled in services Metric - Establish baseline of satisfaction scores Data Source: Press-Ganey satisfaction survey results Process Milestone 1 Estimated Incentive Payment: $16,726	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores Improvement Target: 5% improvement over baseline of patients reporting timely care Data Source: Press-Ganey Patient satisfaction scores Outcome Improvement Target 1 Estimated Incentive Payment: $38,774	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores Improvement Target: 10% improvement over baseline of patients reporting timely care Data Source: Press-Ganey Patient satisfaction scores Outcome Improvement Target 2 Estimated Incentive Payment: $41,478	**Outcome Improvement Target 3** [IT-6.1]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores Improvement Target: 15% improvement over baseline of patients reporting timely care Data Source: Press-Ganey Patient satisfaction scores Outcome Improvement Target 3 Estimated Incentive Payment: $90,171
Year 2 Estimated Outcome Amount:: $16,726	Year 3 Estimated Outcome Amount: $38,774	Year 4 Estimated Outcome Amount: $41,478	Year 5 Estimated Outcome Amount: $90,171
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $187,149			

Title of Outcome Measure (Improvement Target): **IT-1.18: Follow-up After Hospitalization for Mental Illness**

Unique RHP Outcome Identification Number: 133542405.3.1 Pass 1

Performing Provider Name: Austin Travis County Integral Care

Performing Provider TPI: 133542405

Outcome Measure Description

Overall Outcome Measure Description
IT-1.18: Follow-up After Hospitalization for Mental Illness
IT-1.18: Rate 1 – Follow-up visit 30-days after discharge with a mental health practitioner;
Rate 2 – Follow-up visit 7-days after discharge with a mental health practitioner

Process Milestones for Each Year

DY 2: P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans

Metric 2: Assessment/project report and implementation plan

DY 3: P-2: Establish Baseline Rates of Hospitalizations for Mental Illness for Members enrolled at this new clinic site and receiving a follow-up visit within 30-days and 7-days after discharge
Metric 1: Number members enrolled in services at this new outpatient clinic site who are hospitalized for mental illness between January 1 and December 31 of measurement year

DY 4: N/A

DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A

DY 3: N/A

DY 4: IT-1.18: Follow-up After Hospitalization for Mental Illness
Metric 1 IT-1.18: Rate 1 – 50% of members receive a follow-up outpatient visit 30-days after discharge; Rate 2 – 70% of members receive a follow-up outpatient visit 7-days after discharge over baseline

DY 5: IT- 1.18 Follow-up After Hospitalization for Mental Illness.

Metric 1 IT-1.18: Rate 1 – 60% of members receive a follow-up outpatient visit 30-days after discharge; Rate 2 – 80% of members receive a follow-up outpatient visit 7-days after discharge over baseline

Related Category 1 and Category 2 Unique RHP Project Identifiers - 133542405.2.1

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

For DY2, process milestone P-1 was selected to ensure adequate time is invested in assessment, project planning and the finalization of the plan's implementation. A focused, collaborative project planning process will provide opportunity for a deliberate and thoughtful planning process, with ample time to establish a new clinic, reach out to the local community, hire qualified personnel and develop collaborative processes with ATCIC's FQHC partner, CommUnityCare. For DY3, process milestone P-2 was chosen to allow opportunity to establish baseline numbers and ensure appropriate planning in anticipation of achieving improvement targets during DY4 and DY5.

The CNA for RHP-7 reveals that Travis County experienced a 33 percent increase in inpatient hospitalizations from 2008 to 2010. Further, Travis County, suicides are the eighth leading cause of death and the fourth leading preventable cause of death. Research indicates that the weeks after discharge represent a critical period for suicide risk (Hunt et al. Psychological Medicine (2009). 39, 443-449). Establishing a new outpatient clinic location will assist people to receive timely psychiatric follow-up post psychiatric hospitalization. Timely psychiatric follow-up supports a person's psychiatric stabilization and improved functioning. Further, problems that the person encountered prior to and leading to hospitalization may be addressed to assist in averting deterioration in functioning and re-hospitalization. For example: if a person's lack of financial resources resulted in an inability to purchase psychiatric medications with a consequence of worsening functioning led to eventual hospitalization, then clinic staff providing follow-up would promptly address this need thereby supporting the person's continued recovery post-hospitalization.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The improvement targets will be determined in DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

This project addresses the challenge to increase access and the capacity of specialty behavioral health services in Austin and Travis County by establishing a new behavioral health outpatient clinic for children and adults. A fundamental component of this clinic is the integration of primary care services for adults with serious mental illness (SMI), to be done in collaboration with local federally qualified health clinic, CommUnityCare. Throughout the past 10 years, ATCIC has gained considerable experience in providing integrated behavioral health services in primary care clinics with CommUnityCare. Integrated services are a best practice and effective service delivery model used to address the chronic healthcare needs of adults with SMI (http://www.integration.samhsa.gov, August 20, 2012). This new outpatient behavioral health clinic would be located in the Dove Springs neighborhood of Austin and be the first specialty behavioral health clinic in south-southeast Austin - facilitating access to the right care at the right time and setting.

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure

The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing specialty behavioral health services for children/youth and adults in an area of our community south – southeast Austin and the Dove Springs neighborhood. Additionally, integrated primary care/behavioral health services will be provided to adults with SMI at this clinic site thereby providing the right service, at the right time in the right location.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.1	*3.IT-1.18*	*1.18 Follow-up After Hospitalization for Mental Illness*	
Austin Travis County Integral Care			*133542405*
Related Category 1 or 2 Projects:	*133542405.2.1*		
Starting Point/Baseline:	Baseline 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 P-1: Project Planning Metric: Project report and implementation plan Data Source: Project report and implementation plan Process Milestone 1 Estimated Incentive Payment*:* $245,462	**Process Milestone** P-2: Establish Baseline Rates Metric - Number enrolled in services, receiving f/u within specified time frames Goal: To Be Established Data Source: EHR & project data Process Milestone 2 Estimated Incentive Payment: $421,688	**Outcome Improvement Target 1** [IT-1.18]: Follow-up After Hospitalization for Mental Illness Metric: IT-1.18: Rate 1 - Follow-up visit 30-days after discharge; Rate 2 – F/U 7-days after discharge Improvement Target: 5% improvement over baseline Data Source: EHR & project data Outcome Improvement Target 1 Estimated Incentive Payment*:* $451,108	**Outcome Improvement Target 2** [IT-1.18]: Follow-up After Hospitalization for Mental Illness Metric: IT-1.18: Rate 1 - Follow-up visit 30-days after discharge; Rate 2 – F/U 7-days after discharge Improvement Target: 10% improvement over baseline Data Source: EHR & project data Outcome Improvement Target 2 Estimated Incentive Payment*:* $930,294
Year 2 Estimated Outcome Amount: $245,462	Year 3 Estimated Outcome Amount: $421,688	Year 4 Estimated Outcome Amount: $451,108	Year 5 Estimated Outcome Amount: $930,294
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,048,552			

Title of Outcome Measure (Improvement Target): **IT-6.1: Percent Improvement in Satisfaction over baseline of patient satisfaction scores**

Unique RHP Outcome Identification Number: 133542405.3.2

Performing Provider Name: Austin Travis County Integral Care

Performing Provider TPI: 133542405

Outcome Measure Description

Overall Outcome Measure Description

IT-6.1: Percent Improvement in Satisfaction over baseline of patient satisfaction scores – Patients are getting timely care, appointments and information

Process Milestones for Each Year

DY 2: N/A

DY 3: P-2: Establish Baseline Rates
Metric 1: Number individuals enrolled in services, receiving timely f/u, satisfaction scores

DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: [IT-6.1]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores
Improvement Target: 10% improvement over baseline of patients reporting timely care

DY 5: [IT-6.1]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores
Improvement Target: 15% improvement over baseline of patients reporting timely care

Related Category 1 and Category 2 Unique RHP Project Identifiers - 133542405.2.1

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

For DY3, process milestone P-2 was chosen to allow opportunity to establish baseline numbers and ensure appropriate planning in anticipation of achieving improvement targets during DY4 and DY5.

For people with co-morbid conditions, measuring the availability and timeliness of primary care and appointments that meet consumer needs is essential. Measurement of this outcome underscores one of RHP-7 goals of improving the patient experience of care by investing in timely, patient-centered, integrated, comprehensive care that is coordinated across systems

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The improvement targets will be determined in DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

This project addresses the challenge to increase access and the capacity of specialty behavioral health services in Austin and Travis County by establishing a new behavioral health outpatient clinic for children and adults. A fundamental component of this clinic is the integration of primary care services for adults with serious mental illness (SMI), to be done in collaboration with local federally qualified health clinic, CommUnityCare. Throughout the past 10 years, ATCIC has gained considerable experience in providing integrated behavioral health services in primary care clinics with CommUnityCare. Integrated services are a best practice and effective service delivery model used to address the chronic healthcare needs of adults with SMI (http://www.integration.samhsa.gov, August 20, 2012). This new outpatient behavioral health clinic would be located in the Dove Springs neighborhood of Austin and be the first specialty behavioral health clinic in south-southeast Austin - facilitating access to the right care at the right time and setting.

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure

The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing specialty behavioral health services for children/youth and adults in an area of our community south – southeast Austin and the Dove Springs neighborhood. Additionally, integrated primary care/behavioral health services will be provided to adults with SMI at this clinic site thereby providing the right service, at the right time in the right location.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency

room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.2	3.IT-6.1	6.1 Percent Improvement in Patient Satisfaction Scores over Baseline	
Austin Travis County Integral Care			*133542405*
Related Category 1 or 2 Projects:	133542405.2.1		
Starting Point/Baseline:	Baseline 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 - N/A	**Process Milestone 1 -** Determine baseline satisfaction survey scores for individuals enrolled in services Metric - Establish baseline of satisfaction scores Data Source: Press-Ganey satisfaction survey results Process Milestone 1 Estimated Incentive Payment: $421,688	**Outcome Improvement Target 1** [IT-6.1]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores Improvement Target: 10% improvement over baseline of patients reporting timely care Data Source: Press-Ganey Patient satisfaction scores Outcome Improvement Target 1 Estimated Incentive Payment: $451,108	**Outcome Improvement Target 2** [IT-6.1]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores Improvement Target: 15% improvement over baseline of patients reporting timely care Data Source: Press-Ganey Patient satisfaction scores Outcome Improvement Target 2 Estimated Incentive Payment: $930,295
	Year 3 Estimated Outcome Amount: $421,688	Year 4 Estimated Outcome Amount: $451,108	Year 5 Estimated Outcome Amount: $930,295
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,803,091			

Title of Outcome Measure (Improvement Target): **IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate**

Unique RHP Outcome Identification Number: **133542405.3.3 Pass 1**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Outcome Measure Description

Overall Outcome Measure Description

Behavioral Health/Substance Abuse 30 day readmission rate

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

Process Milestones for Each Year

DY 2: P-1: Project Planning
Metric: Project report and implementation plan
Data Source: Project report and implementation plan

DY 3: P-2: Establish Baseline Rates
Metric: Number of targeted individuals served in project
To Be Determined
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A

DY 3: N/A

DY 4: IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. Target is 5 percent decrease below baseline in readmission rates

DY 5: IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. Target is 10 percent decrease below baseline in readmission rates

Related Category 1 and Category 2 Unique RHP Project Identifiers 133542405.2.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

This project is unique in that it calls for MCOT teams to be co-located with four discrete community entities (two local hospital emergency departments housed within two different hospital systems, jail central booking and police). Ensuring good communication across all five systems, including ATCIC, is vital to the success of the project. For DY2, process milestone P-1 was chosen to ensure adequate time will be invested in project planning and finalization of project implementation. A focused, collaborative project planning process will provide opportunity to build this collaboration and partner with all five entities in a deliberate and thoughtful planning process. For DY3, process milestone P-2 was chosen to allow opportunity to establish baseline numbers and ensure appropriate planning in anticipation of achieving improvement targets during DY4 and DY5. For DY4 and DY5, we selected improvement milestone IT-38, Behavioral Health/Substance Abuse 30 day readmission rates. We project improving over baseline by 5 percent in DY4 and 10 percent in DY5.

The location of the MCOT teams at these key community emergency system intercept points creates a unique opportunity to divert individuals from the emergency system to alternative community-based services. Because ATCIC is the local behavioral health authority for Travis County, ATCIC's electronic health records (EHR's) will contain information about previous hospitalizations and clinical notes for ATCIC consumers, including individual care managed through ATCIC's authority function. In instances of potential readmissions, MCOT staff gain an advantage by having immediate access to an individual's EHR that is specific to the previous hospitalization and clinical notes since discharge. Having this information allows MCOT to engage the consumer and other community entity representatives in "real time" and formulate an alternative disposition to hospitalization if clinically appropriate.

For DY4 and DY5, we selected a benchmark of 5 percent and 10 percent respectively based on the CNA for RHP-7 that reveals Travis County experienced a 33 percent increase in inpatient hospitalizations from 2008 to 2010. Also, data for FY12 year to date shows that readmission rates to inpatient psychiatric hospitals within 30 days are 14.4 percent, a two percent increase from FY11 (Central Health, CIC, 9/12 Report).

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Not Applicable

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

ATCIC proposes expanding MCOT capacity at key community intercept points to provide specialty behavioral health crisis intervention services. As a best practice model in the field of psychiatric crisis care, MCOT's are designed to go out to the community to provide site based psychiatric crisis intervention services to assess and stabilize an individual experiencing immediate behavioral health crisis (ie, an individual at immediate risk of harm to self or others due to a mental health condition). MCOT's are also designed to provide short-term follow up services to further stabilize an individual experiencing a behavioral health crisis and link the individual to appropriate resources. ATCIC proposes adding MCOT employees 24/7 to the following critical community intercept points: Travis County Jail at central booking, the two highest psychiatric volume emergency departments (Seton's University Medical Center Emergency Department and St. David's South Austin Emergency Department) and law enforcement (by pairing MCOT staff 24/7 with two trained Mental Health Crisis Intervention Team officers).

This expansion will meet the goals to divert inpatient admissions, jail bookings and emergency department admissions and provide short-term community-based intervention to stabilize a person in a psychiatric crisis and link them to ongoing supports.

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure

The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and cost reduction to the healthcare system. In considering the incentive portion of the valuation, three principles and their subsequent impacts were considered. These principles include: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing psychiatric services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. By adding MCOT capacity at key community intercept points (Travis County Jail central booking, the two highest psychiatric volume emergency departments and paired with two trained Mental Health Crisis Intervention Team law enforcement officers), an opportunity is created to divert inpatient psychiatric admissions, jail bookings and emergency department (ED) admissions, provide short-term community-based interventions to stabilize a person in a psychiatric crisis and link these individuals to ongoing supports.

Calculating the value of interventions for this project for a specialty behavioral health population was done using an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system. These individuals also frequently present with a number of functional impairments, which lead to involvement in the criminal justice system. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare and criminal justice systems.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.3	***IT-3.8***	***IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate***	
Austin Travis County Integral Care			***133542405***
Related Category 1 or 2 Projects:	***133542405.2.2***		
Starting Point/Baseline:	Baseline to be Determined		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 2: Project report and implementation plan Data Source: Project report and implementation plan Process Milestone 1 Estimated Incentive Payment: $268,876	**Process Milestone 2** P-2: Establish Baseline Rates Metric 1: Number of targeted individuals served in project Baseline/Goal: To Be Determined Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $1,412,335	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health/Substance Abuse 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 behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than one readmission, only the first is counted as a readmission. b. Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission Improvement Target: 5% improvement over baseline Data Source: EHR	**Outcome Improvement Target 2** [IT-1.1]: IT-3.8: Behavioral Health/ Substance Abuse 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 behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than one readmission, only the first is counted as a readmission. b. Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission Improvement Target: 10% improvement over baseline

133542405.3.3	***IT-3.8***	***IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate***	
Austin Travis County Integral Care			***133542405***
Related Category 1 or 2 Projects:	***133542405.2.2***		
Starting Point/Baseline:	Baseline to be Determined		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Estimated Incentive Payment*:* $1,851,819	Data Source: EHR Estimated Incentive Payment*:* $1,997,840
Year 2 Estimated Outcome Amount: $268,876	Year 3 Estimated Outcome Amount: $1,412,335	Year 4 Estimated Outcome Amount: $1,851,819	Year 5 Estimated Outcome Amount: $1,997.840
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $5,530,870			

Hospital and Jail Diversion Alternative Project: **Crisis Residential Program**

Title of Outcome Measure (Improvement Target): **IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate**

Unique RHP Outcome Identification Number: **133542405.3.7 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Outcome Measure Description

Overall Outcome Measure Description

Behavioral Health/Substance Abuse 30 day readmission rate

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

f. 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

Process Milestones for Each Year

DY 2: P-1: Project Planning

Metric: Project report and implementation plan

Data Source: Project report and implementation plan

DY 3: P-2: Establish Baseline Rates
Metric: Number of targeted individuals served in project
Baseline/Goal: To Be Determined

DY 4: N/A

DY 5: N/A

Outcome Improvement Targets for Each Year

DY 2: N/A

DY 3: N/A

DY 4: IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. Target is 5% decrease over baseline in readmission rates

DY 5: IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate. Target is 10% decrease over baseline in readmission rates

Related Category 1 and Category 2 Unique RHP Project Identifiers 133542405.2.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

For DY2, process milestone P-1 was chosen to ensure adequate time will be invested in project planning and finalization of project implementation. A focused, collaborative project planning process will provide opportunity to develop this project working with community partners. For DY3, process milestone P-2 was chosen to allow opportunity to establish baseline numbers and ensure appropriate planning in anticipation of achieving improvement targets during DY4 and DY5.

For DY4 and DY5, we selected a benchmark of five and ten percent respectively based on two sets of data. The first comes from the CNA for RHP-7, that reveals Travis County experienced a 33 percent increase in inpatient hospitalizations from 2008 to 2010. The second is data for FY12 year to date showing that readmission rates to inpatient psychiatric hospitals within 30 days is 14.4 percent, a two percent increase from FY11 (Central Health, CIC, 9/12 Report). Adding crisis residential treatment capacity will create additional system capacity so that more individuals can be maintained and helped in the community as an alternative to higher cost settings such as hospitals or jails due to lack of viable community alternative treatment options.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The improvement targets will be determined in DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

With 26 percent population growth in Travis County from 2000-2006 and a projected seven percent growth rate through 2016, the demand on the community's psychiatric crisis safety net will increase *(RHP-7, CNA, Central Health, Travis County, Sept. 2012).* The proposed crisis residential project, targeting individuals who have co-occurring substance use and mental health disorders experiencing a psychiatric crisis, was selected to ensure individuals receive appropriate, cost-effective and specialized treatment as an alternative to hospitalization and incarceration to:

(4) Reduce the burden and costs on local EDs and increase both consumer and public safety by providing specialized behavioral health services;
(5) Provide behavioral health treatment alternatives to incarceration;

Outcome Measure Valuation

Approach and Rationale for Valuing Project - The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and cost reduction to the healthcare system. In considering the incentive portion of the valuation, three principles and their subsequent impacts were considered. These principles include: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system. This project specifically addresses the unmet need of providing specialty co-occurring substance use and psychiatric crisis services (evaluation, diagnosis and treatment) for adults at the right time and in the right place. The proposed crisis residential program will specialize in providing psychiatric crisis care for individuals diagnosed with co-occurring substance use and mental health disorders and will include services such as psychiatric screening and psychiatric crisis assessment, access to a prescriber and medications, 24-hour nursing care, intensive care management, linkage to on-going care and other resources, rehabilitative skills building and counseling to ensure the individual's immediate crisis is stabilized. Given the prevalence of co-occurring mental health and substance use disorders and the lack of existing specialized crisis residential treatment alternatives for this population, the proposed crisis residential program represents a much needed community based specialty alternative for diverting potentially preventable behavioral health and criminal justice admissions and readmissions.

Calculating the value of interventions for this project for a specialty behavioral health population was done using an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis w to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system. These individuals also frequently present with a number of functional impairments, which lead to involvement in the criminal justice system. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare and criminal justice systems.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.7	***IT-3.8***	***IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate***	
Austin Travis County Integral Care			***133542405***
Related Category 1 or 2 Projects:	***133542405.2.3***		
Starting Point/Baseline:	Number of targeted individuals served to be determined		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project Planning <u>Metric 2</u>: Project report and implementation plan Data Source: Project report and implementation plan Process Milestone 1 Estimated Incentive Payment*:* $191,211	**Process Milestone 2** P-2: Establish Baseline Rates <u>Metric 1</u>: Number of targeted individuals served in project Baseline/Goal: To Be Determined Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $443,278	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health/ Substance Abuse 30 day readmission rate c. Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than one readmission, only the first is counted as a readmission. d. 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 Target: 5% improvement over baseline Data Source: EHR Estimated Incentive Payment*:* $474,204	**Outcome Improvement Target 2** [IT-1.1]: IT-3.8: Behavioral Health/ Substance Abuse 30 day readmission rate c. Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than one readmission, only the first is counted as a readmission. d. 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 Target:10% improvement over baseline Data Source: EHR Estimated Incentive Payment*:* $1,030,878
Year 2 Estimated Outcome Amount: $191,211	Year 3 Estimated Outcome Amount: $443,278	Year 4 Estimated Outcome Amount: $474,204	Year 5 Estimated Outcome Amount: $1,030,878

133542405.3.7	*IT-3.8*	*IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate*	
Austin Travis County Integral Care			*133542405*
Related Category 1 or 2 Projects:	*133542405.2.3*		
Starting Point/Baseline:	Number of targeted individuals served to be determined		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,139,571			

Title of Outcome Measure (Improvement Target): ***IT 9.2*** **- ED Appropriate Utilization**

Unique RHP Outcome Identification Number: **133542405.3.8 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Outcome Measure Description

Overall Outcome Measure Description

ED Appropriate utilization (Standalone measure)

- Reduce all ED Visits
- Reduce Pediatric Emergency Department visits
- Reduce Emergency Department visits for individuals with co-occurring IDD/MI

Process Milestones for Each Year

DY 2: P-1 Project Planning
Metric: Project Report and implementation plan
Data Source: Project Report and implementation plan

DY 3: P-2 Establish Baseline Rates
Metric: Number of targeted individuals served in project
Data Source: Baseline Goal to be determined

DY 4: N/A

DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A

DY 3: N/A

DY 4: IT-9.2 ED appropriate utilization. Target is five percent over baseline of population reached

DY 5: IT-9.2: ED appropriate utilization. Target is 10 percent increase over baseline of population reached.

Related Category 1 and Category 2 Unique RHP Project Identifiers- 133542405.2.4

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
This project strives to be the single point of referral prior to ED visits or for other inpatient care designed to treat individuals who have an IDD diagnosis and are experiencing a psychiatric emergency. Currently, individuals are often taken to ED's for assessment and referral as needed. ED's however, do not have settings that are conducive to provide the specialized treatment and care needed. Dispatching our specialty CBS Team to a person's location (including ED's) to assess and provide appropriate referrals reduce the chances for an unnecessary visit to the ED. This program's success will be determined by documenting a decrease in the frequency that individuals who require this specialized care turn to local EDs, as they feel they have nowhere else to go.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
The improvement targets will be determined in DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
ATCIC proposes creating a community-based, specialized team designed to intervene during times of crisis for those with co-occurring IDD/MI diagnosis. This community-based service, offering a continuum of care for the duration of the current crisis, will fill the current gap where acute care and crisis services are currently deemed inadequate in Travis County (Central Health, CIC, 9/12 Report).

ATCIC, partners, and other stakeholders agree and have an established body committed to achieving this goal so that individuals with IDD can remain in their own homes and communities without risk of returning, or remaining in a restrictive environment.

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure - ATCIC Waiver projects approached valuation considering three primary elements: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. Consideration in determining the incentive portion of the valuation included three principles and their subsequent impacts including; investments required to initiative the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement; and incentives to the performing provider to accelerate transformation of delivery system.

This project specifically addresses the ability to provide crisis prevention, intervention, and stabilization for this population in the most integrated and appropriate settings based on an individual's needs. The CBS Team will achieve this by developing adequate community-based supports that prevent involvement with criminal justice systems, institutionalization, hospitalization, homelessness, or in some cases – death.

The valuation for this targeted intervention was completed using an economic evaluation model, performed by a medical economist. This model used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com. Current systems are ineffective for this

targeted population. The interventions described within this program are designed to reduce trends and positively impact our regions' health care delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.8	IT 9.2	IT 9.2 ED Appropriate Utilization	
Austin Travis County Integral Care			133542405
Related Category 1 or 2 Projects:	133542405.2.4		
Starting Point/Baseline:	TBD 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. Metric 1: Project Report Data Source: Project Plan and documentation from planning meetings. Estimated Incentive Payment: $25,765 **Process Milestone 2** P-2 Establish Baseline Rates. Metric 1: Number of individuals with co-occurring diagnoses seeking psychiatric care at EDs Baseline/Goal: TBD Data Source: EHR & ED records Estimated Incentive Payment: $25,765	**Process Milestone 3** P-3 Develop and test data systems. Metric 1: Select parameters for data reporting and identify data systems. Data Source: Reports from data system Estimated Incentive Payment: $59,730 **Process Milestone 4** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Metric 1: Produce report of PDSA results and recommendations. Baseline/Goal: TBD Data Source: PDSA Report Estimated Incentive Payment: $59,730	**Outcome Improvement Target 1** IT-9.2: ED appropriate utilization Improvement Target: 5% increase over baseline Data Source: EHR & ED records Outcome Improvement Target 1 Estimated Incentive Payment*:* $127,795	**Outcome Improvement Target 2** IT-9.2: ED appropriate utilization Improvement Target: 10% increase over baseline Data Source: EHR & ED records Outcome Improvement Target 2 Estimated Incentive Payment*:* $277,814
Year 2 Estimated Outcome Amount:: $51,530	Year 3 Estimated Outcome Amount: $119,460	Year 4 Estimated Outcome Amount: $127,795	Year 5 Estimated Outcome Amount: $277,814
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*: $576,599*			

Title of Outcome Measure (Improvement Target): **IT-6.1 Percent improvement over baseline of patient satisfaction scores – patient's overall health status/functional status**

Unique RHP Outcome Identification Number: **133542405.3.9 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: **133542405**

Outcome Measure Description

Overall Outcome Measure Description

OD-6 Patient Satisfaction

IT-6.1.5: Percent Improvement in Satisfaction over baseline of patient satisfaction scores – Patients overall health/functional status

Process Milestones for Each Year

DY 2: P-2: Establish Baseline Rates

Metric 1: Number individuals enrolled in services with chronic disease(s)

DY 3: P-3: Develop and test data systems

Metric 1: Production of prevalence and enrolled receiving CDM services reports

DY 4: P-9 Evaluate and continuously improve CDM self-management programs

DY 5: Participate in two yearly meetings with RHP providers to share project experience and and promote learning's.

Outcome Improvement Targets for Each Year:

DY 2: IT-6.1.5: For Domain 1, Percent improvement over baseline of patient satisfactions scores. Patients report satisfaction in improvement of overall health/functional status. (10% Improvement)

DY 3: IT-6.1.5: For Domain 1, Percent improvement over baseline of patient satisfactions scores. Patients report satisfaction in improvement of overall health/functional status. (10% Improvement)

DY 4: IT-6.1.5: For Domain 1, Percent improvement over baseline of patient satisfactions scores. Patients report satisfaction in improvement of overall health/functional status. (10% Improvement)

DY 5: IT-6.1.5: For Domain 1, Percent improvement over baseline of patient satisfactions scores. Patients report satisfaction in improvement of overall health/functional status (15% Improvement)

Related Category 2 Unique RHP Project Identifier: 133542405.2.5

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

For DY2, process milestone P-2 was selected because establishing a baseline of the number of consumers who have chronic diseases, smoke, are obese and lack sufficient daily activity (CD prevalence) is needed in order to enroll them in Chronic Disease Management (CDM) programs. This information will be collected from EHR and health risk data that will be gathered by administering an HRA developed by the CDC to all adult consumers with SMI. National and state prevalence data of people with SMI who have a chronic

disease varies for CAD, diabetes, smoking and obesity, but average about 40 percent for all conditions. In addition, process milestone P-2 was chosen to ensure the appropriate data and planning efforts to achieve improvement targets during DY4 and DY5.

For DY3, process milestone P-3 was selected because a database containing aggregated HRA and health status data will need to be created to establish prevalence, enroll consumers in CDM programming, track program progress and track satisfaction survey results. The outcome improvement target was selected because of the availability of pre-post intervention data on functional/health status.

For DY4, process milestone P-9 was chosen to demonstrate the utilization of PDSA QI methodology for the ongoing evaluation of the project.

For DY5, process milestone P-11 was chosen in order to expand the reach of the program's impact by participating in semi-annual face-to-face meetings or seminars organized by the RHP in which project progress and learning's are shared.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
The improvement targets will be determined in DY2.

Briefly describe how the related Category 2 projects will achieve this outcome measure.
This project addresses the challenge of systematically identifying, enrolling and treating adults with SMI with co-morbid chronic disease conditions with several best practice CDM programs. These programs specialize in highly individualized plans, coaching by assigned dietary/smoking cessation/exercise specialists with a focus on plans developed through the use of motivational interviewing techniques. Through implementing the chronic disease prevention/management program and improving patient's health and focusing on wellness and healthy lifestyles we expect to see overall patient satisfaction and improved functional status

Outcome Measure Valuation

Approach and Rationale for Valuing Outcome Measure - Calculating the value of interventions for this project for a specialty behavioral health population (adults with SMI and concurrent chronic disease) used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This valuation used cost-utility analysis to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., hospital admissions for chronic disease conditions are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com. The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI and chronic disease are intensive users of the healthcare system at rates much higher than the non_SMI population and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.9	*IT-6.1*	*Percent Improvement in Satisfaction over baseline of pt. satisfaction scores on patient's overall health/functional status*	
Austin Travis County Integral Care			*133542405*
Related Category 1 or 2 Projects:	*133542405.2.5*		
Starting Point/Baseline:	ATCIC currently operates two adult outpatient clinics and in FY 2012 served approximately 7,500 adults, of which approximately 40 percent have one or more chronic diseases. The overall program goal is to identify and target these consumers with specialized chronic disease programming.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 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 Baseline/Goal: To be determined Data Source: EHR & satisfaction scores Estimated Incentive Payment: $39,476 **Outcome Improvement Target 1** **[I**T-6.1.5]: For Domain 1, Percent improvement over baseline of patient satisfactions scores. Patients report satisfaction in improvement of overall health/functional status. (10% Improvement). Data Source: Patient satisfaction scores Estimated Incentive Payment: $39,476	**Process Milestone** 2 P-3: Develop/test data systems Baseline/Goal: To be determined Data Source: EHR & satisfaction scores Estimated Incentive Payment: $91,515 **Outcome Improvement Target 2** **[I**T-6.1.5]: For Domain 1, Percent improvement over baseline of patient satisfactions scores. Patients report satisfaction in improvement of overall health/functional status. (10% Improvement). Data Source: Patient satisfaction scores Estimated Incentive Payment: $91,516	**Outcome Improvement Target 3** [IT-6.1.5]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores Improvement Target: 10% improvement over baseline of patients reporting overall health/functional status Data Source: Patient satisfaction scores Estimated Incentive Payment: $97,800 **Process Milestone 3 [**P-9] Evaluate and continuously improve CDM self-management programs Baseline/Goal: 2 PIP projects Data Source: Program data from EHR and reports. Estimated Incentive Payment: $97,801	**Process Milestone 4 [**P-11] Participate in two yearly meetings with RHP providers to share project experience and promote learning. Baseline/Goal: 2 meetings/year Data Source: Meeting minutes Estimated Incentive Payment: $212,826 **Outcome Improvement Target 6** [IT-6.1.5]: Percent Improvement in Satisfaction over baseline of pt. satisfaction scores Improvement Target: 15% improvement over baseline of patients reporting overall health/functional status Data Source: Patient satisfaction scores Estimated Incentive Payment: $212,827
Year 2 Estimated Outcome Amount: $78,952	Year 3 Estimated Outcome Amount: $183,031	Year 4 Estimated Outcome Amount: $195,801	Year 5 Estimated Outcome Amount: $425,653
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $883,437			

Title of Outcome Measure (Improvement Target): **6.1.5 Percent Improvement in Satisfaction over baseline of pt. satisfaction scores on patient's overall health/functional status for those involved in Peer Support programs**

Unique RHP Outcome Identification Number: **133542405.3.10 Pass 2**

Performing Provider Name: **Austin Travis County Integral Care**

Performing Provider TPI: ***133542405***

Outcome Measure Description

Overall Outcome Measure Description
Improved satisfaction with care delivered for those involved in Peer Support programs

Process Milestones for Each Year
DY 2: Establish baseline rates
DY 3: Overall satisfaction with services compared to baseline
DY 4: Overall satisfaction with services compared to baseline
DY 5: Overall satisfaction with services compared to baseline

Outcome Improvement Targets for Each Year:
DY 2: Assess baseline satisfaction for those involved in Peer Support programs
DY : 5% improvement in satisfaction for those involved in Peer Support programs
DY 4: 10% improvement in satisfaction for those involved in Peer Support programs
DY 5: 15% improvement in satisfaction for those involved in Peer Support programs
Note: all improvement targets are compared to DY2 baseline

Related Category 1 and Category 2 Unique RHP Project Identifiers: 133542405.2.6

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
ATCIC hypothesizes that individuals who participate in peer support programs experience improved service satisfaction when engaged by peers who are also experiencing severe psychiatric illnesses.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
NA

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
As ATCIC adds chronic disease management and health living alternatives to traditional peer support training and approaches, overall care satisfaction will improve.

Outcome Measure Valuation

Approach and Rationale for Valuing Project – The approach to valuing this and all ATCIC Waiver projects considered three primary factors: factors related to an improved patient experience, the benefit to our community, and costs reduction to healthcare system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These the principles included:

investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation of the delivery system.

Calculating the value of interventions for this project for a specialty behavioral health population used an economic evaluation model and extensive review of the literature conducted by H. Shelton Brown, Ph.D. at the University of Texas – Houston School of Public Health and Thomas Bohman, Ph.D. at the University of Texas – Austin Center for Social Work Research. This model employs a costs-utility analysis was to measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528; http://download.journals.elsevierhealth.com The QALY value results in significant and meaningful values related to behavioral health interventions. Adults with SMI are often intensive users of the healthcare system and frequently present with a number of functional impairments for effective social functioning. Incremental improvements in their behavioral and physical health status have significant impact on the improvement of the person's experience, benefit to the community, and the reduction of costs to the healthcare delivery system.

All project narratives and a description of the method used, titled 'Valuing Transformation Projects,' can be found on the performing provider website at IntegralCare.org under the Medicaid 1115 Transformation Waiver tab.

133542405.3.10	Category 3 IT-6.1	6.1.5 Percent Improvement in Satisfaction over baseline of pt. satisfaction scores on patient's overall health/functional status for those involved in Peer Support programs	
Austin Travis County Integral Care			133542405
Related Category 1 or 2 Projects:	133542405.2.6		
Starting Point/Baseline:	ATCIC currently operates multiple adult outpatient service sites and in FY 2012 served approximately 7,500 adults. ATCIC and the other community mental health centers have not fully explored or engaged individuals with SMI in Peer Support Programs. There is no regional coordination of training Peer Support Specialists.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone: P-1:Establish Baseline Rates Metric: Number enrolled in services, overall health functional status satisfaction scores Baseline/Goal: To be determined Data Source: Satisfaction scores Process Milestone 1 Estimated Incentive Payment*:* $14,214	**Process Milestone** P-2: Establish Baseline Rates Metric: IT-6.1.5 - 5% improvement over DY-2 baseline of patients reporting overall health/functional status Data Source: Satisfaction scores Process Milestone 2 Estimated Incentive Payment: $32,951	**Outcome Improvement Target 1** IT-6.1.: Percent Improvement in Satisfaction over baseline of patient satisfaction scores Metric: IT-6.1.5 - 10% improvement over DY-2 baseline of patients reporting overall health/functional status Data Source: Patient satisfaction scores Outcome Improvement Target 1 Estimated Incentive Payment*:* $35,250	**Outcome Improvement Target 2** IT-6.1: Percent Improvement in Satisfaction over baseline of patient satisfaction scores Metric: IT-6.1.5 - 15% improvement over DY-2 baseline of patients reporting overall health/functional status Data Source: Patient satisfaction scores Outcome Improvement Target 1 Estimated Incentive Payment*:* $76,630
Year 2 Estimated Outcome Amount: $14,214	Year 3 Estimated Outcome Amount: $32,951	Year 4 Estimated Outcome Amount: $35,250	Year 5 Estimated Outcome Amount: $76,630
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $159,045			

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): *IT-6.1 Percent improvement over baseline of patient satisfaction scores*

Unique RHP Outcome Identification Number: 126844305.3.1 Pass 1

Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services

Performing Provider TPI: **126844305**

Outcome Measure Description

Overall Outcome Measure Description
IT-6.1 Percent improvement over baseline of patient satisfaction scores
We will use the entire Child CG-CAHPS Tool

Process Milestones for Each Year

DY 2: P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
DY 3: P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-6.1: 10%Percent improvement over baseline of patient satisfaction scores
DY 5: IT-6.1: 15% Percent improvement over baseline of patient satisfaction scores

Related Category 1 and Category 2 Unique RHP Project Identifiers

1268443-05.1.1

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
DY 2 will be a short year with only 6 months to perform, but important to engage stakeholders, achieve formal agreements with school districts, select a satisfaction instrument, develop policy manuals, hire and recruit and hire staff. We will put our efforts into infrastructure development and community education;

and we will begin the PDSA implementation as we begin development. The Quality Management Department of Bluebonnet Trails community Services will lead this effort. We will continue making adjustments in care and services as we continue the PDSA cycle into DY 3.
The Improvement Target for DY 4 and 5 is a stand-alone measure because we plan to use the Child CG-CAHPS in its entirety and measure overall improvement in satisfaction on all domains.

The Outcome Measure was selected because we expect it to support evidence of achievement of two of CMS's triple aims; improved access and improved quality. Patient experience is one of the best gauges of health care system improvement. We will select a valid child and family satisfaction instrument that measures the 5 areas above. If we record the improvement expected we believe it will be a mark of success in progress toward improved access and quality.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
We will select an instrument that measures both youth and family satisfaction. The project is to provide ready access in school to counseling and early intervention. Establishing this program in schools and working with school staff and counseling staff to achieve acceptance and improving utilization will begin to lead to satisfaction. As youth and families increase utilization we expect improved school and home functioning and therefore improvement in satisfaction.

Outcome Measure Valuation

Approach for Valuing Outcome Measure
This project will seek to serve 75 youth in DY 4 and 100 youth in DY5. These are very high intensity youth who are at risk to be removed from home and placed in a psychiatric hospital or residential treatment facility. Both of these options are expensive and separate the family from the treatment process and seriously reducing the chances for reunification with the family. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation
We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to crisis services provided in this non-traditional way. We are able to compare value of

service for Therapeutic Foster Care against traditional institutional care. Reunification and family preservation are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these disparate factors.

126844305.3.1	*3.IT 6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.1.1*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Program Documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $10,146 **Process Milestone 2** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Program Documents, Quality Management plans; performance reports and records	**Process Milestone 3** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Program Documents, Quality Management plans; performance reports and records Process Milestone 2 Estimated Incentive Payment: $43,381	**Outcome Improvement Target 1** IT-6.1 10% improvement over baseline of patient satisfaction scores Data Source: Child CG-CAHPS Satisfaction Surveys and Summary Results Outcome Improvement Target 1 Estimated Incentive Payment*:* $48,183	**Outcome Improvement Target 2** [IT-6.1]: 15% improvement over baseline of patient satisfaction scores Data Source: Child CG-CAHPS Satisfaction Surveys and Summary Results Outcome Improvement Target 2 Estimated Incentive Payment*:* $106,003

126844305.3.1	*3.IT 6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.1.1*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 2 Estimated Incentive Payment: $10,147			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $20,293	Year 3 Estimated Outcome Amount $43,381	Year 4 Estimated Outcome Amount: $48,183	Year 5 Estimated Outcome Amount: $106,003
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $217,860			

Title of 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: 126844305.3.2 Pass 1

Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services

Performing Provider TPI: 126844305

Outcome Measure Description

Overall Outcome Measure Description
OD-9 Right Care, Right Setting
IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
Process Milestones for Each Year

DY 2: P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3: P- 2 Establish baseline rates
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings.
DY 5: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings.

Related Category 1 and Category 2 Unique RHP Project Identifiers

126844305.1.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
We selected project planning and stakeholder engagement as the Process Milestones for DY2 because we need to accomplish these foundational tasks in order to establish Crisis Respite through TFC. Establishing this crisis stabilization alternative to referral to juvenile probation in order to secure an inpatient or secure residential setting will achieve the Outcome. We selected the DY3 Process Milestone because we need a year of operation to establish the number served and we need time to gather additional juvenile justice system data concerning the number referred for mental health services in order to measure our Improvement Target.

The Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help youth successfully return to family and community. Unfortunately lack of behavioral health resources has led to the juvenile justice system providing access to care. Juvenile Probation Departments in these counties are major partners and therefore we feel that reducing the number of removals from home and community is one of the best measures of success.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The Outcome Measure is to provide the Right Care in The Right Setting and thereby decrease in mental health admissions and readmissions to criminal justice settings. The project proposed is to establish a crisis stabilization alternative that will allow for stabilization in the community. Due to safety and security concerns, families and the community currently refer youth to juvenile justice even though the problem is a mental health problem because there is no other safe stabilization alternative. Providing such an alternative gives us the opportunity to achieve this Outcome.

Outcome Measure Valuation

Approach for Valuing Outcome Measure
We expect to serve about 12 youth in DY 4 and 15 in DY 5. The benefit to youth is being able to stay in their natural families. These are very high intensity youth who otherwise would be removed from home and placed in a psychiatric hospital or residential treatment facility. Both of these options are expensive and separate the family from the treatment process and seriously reducing the chances for reunification with the family. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation
We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to crisis services provided in this non-traditional way. We are able to compare value of service for Therapeutic Foster Care against traditional institutional care. Reunification and family

preservation are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these disparate factors.

126844305.3.2	*3.IT 9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.1.2*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Program Documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $35,112	**Process Milestone 2** [P- 2]: Establish baseline rates. Data Source: Juvenile justice system records, local MH authority and state MH data system records. Process Milestone 2 Estimated Incentive Payment: $94,760	**Outcome Improvement Target 1** [IT-9.1]: Decrease in mental health admissions and readmissions to juvenile justice settings. Improvement Target: Decrease in mental health admissions and readmissions to juvenile justice settings by TBD % of baseline from DY3. Data Source: Juvenile justice system records, local MH authority and state MH data system records Outcome Improvement Target 1 Estimated Incentive Payment*:* $96,743	**Outcome Improvement Target 1**[IT-9.1]: Decrease in mental health admissions and readmissions to juvenile justice settings. Improvement Target: Decrease in mental health admissions and readmissions to juvenile justice settings by TBD % of baseline from DY3. Data Source: Juvenile justice system records, local MH authority and state MH data system records Outcome Improvement Target 2 Estimated Incentive Payment*:* $157,276
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $35,112	Year 3 Estimated Outcome Amount: $94,760	Year 4 Estimated Outcome Amount: $96,743	Year 5 Estimated Outcome Amount: $157,276

126844305.3.2	*3.IT 9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.1.2*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $383,891			

Title of Outcome Measure (Improvement Target): OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

Unique RHP Outcome Identification Number: 126844305.3.4

Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services

Performing Provider TPI: 126844305

Outcome Measure Description

Overall Outcome Measure Description
IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Process Milestones for Each Year

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

DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A

- ***DY4: IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate.***
- ***DY5: IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate.***

Related Category 1 and Category 2 Unique RHP Project Identifiers

126844305.1.3

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
Process Milestones – P-2 and P-3 were chosen because although the clinic will begin operating in DY 2, there are no current services and therefore initial policies procedures and protocols need to be developed. Also we must complete these to obtain facility licensure. As we begin operations in DY 2, we will then need to apply a PDSA cycle to assure that operations are correct and meeting the needs of the clients. Data systems to collect surveys and to summarize and report will be put in place in DY3. Another PDSA cycle will be used to assure accuracy, sufficient sample size and reporting infrastructure that supports communication and utility.

Improvement Target was chosen because the goal of this project is to help people who have been in some inpatient or other detoxification program and those who self-refer to transition to stable living in the community by providing access to community outpatient services. The Improvement Target for DY 4 and 5 is a stand-alone measure. Through this project we will help people who have been in some inpatient or other detoxification program to transition to stable living in the community by providing access to community outpatient services. We will measure the reduction in readmissions that we are confident will result from local access to intensive and supportive community based services.
.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The cycle of relapse and return to hospital or residential detoxification services is a major disruption for individuals seeking to achieve recovery. It is also costly to the health care system and devastating to individuals and families. We believe that achieving a sustained self-report of quality of life improvement will increase the length of time in recovery and improve the chance for long term recovery. This will be a good indicator of success for the program and a good indicator of success on a personal basis for those enrolled in the program. Low income individuals cannot now access outpatient care and are left in this cycle of relapse. Extending access to all in the community will improve overall community health and individual quality of life.

Outcome Measure Valuation

Approach for Valuing Outcome Measure
We seek to serve 750 people in this new service in DY 4 and 1,000 in DY 5. The outcome for this project will be a reduction in re-hospitalization which is a good indicator of success for the program and a good indicator of success on a personal basis for those enrolled in the program. Low income individuals cannot now access outpatient care and are left in this cycle of relapse. Extended sobriety and productivity will improve their health outcomes. The valuation calculated for this outcome used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the

Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to traditional substance abuse outpatient services in relation to psychosocial and case management based mental health services. We should be able to compare value across these very different modalities.

126844305.3.4	*3.IT 3.8*	*Behavioral Health / Substance Abuse 30 day readmission rate*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.1.3*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [[P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program documentation, agenda and minutes Process Milestone 1 Estimated Incentive Payment (maximum amount): $24,256 **Process Milestone 2:** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Program documentation, data reports and BI Process Milestone 2 Estimated Incentive Payment (maximum	**Process Milestone 3** [P- 3]: Develop and test data systems. Data Source: Program documentation, return rate of surveys. Process Milestone 3 Estimated Incentive Payment: $55,515 **Process Milestone 4:** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Program documentation, data reports and BI Process Milestone 4 Estimated Incentive Payment (maximum amount): $55,515	**Outcome Improvement Target 1:** 3.8 Behavioral Health /Substance Abuse 30 day readmission rate. Baseline: TBD in DY 3 Improvement Target**:** Rate TBD Data Source: Hospital Records Outcome Improvement Target 1 Estimated Incentive Payment: $118,593	**Outcome Improvement Target 2:** 3.8 Behavioral Health /Substance Abuse 30 day readmission rate. Baseline: TBD in DY 3 Improvement Target**:** Rate TBD Data Source: Hospital Records Outcome Improvement Target 2 Estimated Incentive Payment: $257,989

126844305.3.4	*3.IT 3.8*	*Behavioral Health / Substance Abuse 30 day readmission rate*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.1.3*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
amount): $24,257			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $48,513	Year 3 Estimated Outcome Amount $111,030	Year 4 Estimated Outcome Amount: $118,593	Year 5 Estimated Outcome Amount: $257,989
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $536,125			

Title of Outcome Measure (Improvement Target): *IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate*

Unique RHP Outcome Identification Number: 126844305.3.3

Performing Provider Name: *Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services*

Performing Provider TPI: **126844305 Pass 1**

Outcome Measure Description

Overall Outcome Measure Description
OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates
IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rates.

Process Milestones for Each Year

DY 2: P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
P- 2 Establish baseline rates
P- 3 Develop and test data systems
DY 3: P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P- 5 Disseminate findings, including lessons learned and best practices, to stakeholders
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate
DY 5: IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Related Category 1 and Category 2 Unique RHP Project Identifiers

1268443-05.2.1

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
As stated in the Category 2 Project Narrative, this is a new project for this County and for BTCS. We are also employing peer support in the project which is system reform approach, engaging peers in helping one another and in full participation in their recovery. The Process Measures selected for DY 2 reflect the new and innovative nature of these activities. We need to get input from stakeholders and develop detailed implementation plans and timelines. Also there is no baseline since the project does not now exist

in the Region, so data systems have to be identified, developed and tested in order to establish the baseline to move forward. Process Measures for DY 3 were selected so that we can establish a set of quality improvement processes to support process improvement going forward. The Quality Management Department of BTCS will use the Process steps to continue a Quality Improvement process throughout the project.
The Improvement Target selected for both DY 4 and 5 are related to the goals of the project in that achievement of the goals will improve overall functioning and skills to self-manage wellness, which will result in reduced readmissions for this target population.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
Wellness, self-management and a place to live that is one's own are fundamental building blocks for recovery. The Transitional Housing Guided by Peer Support project assists people in their recovery, provides resources to support wellness and self-management, and integrates people into housing of their own in the community. Stability and improved functioning reduces disruptive admissions to hospital and use of emergency services. Stable community tenure is another key contributor to improved quality of life. The evidence based practices we reviewed all contain components supporting skills development, self-awareness and individual responsibility in the recovery process. Recovery which leads to improved functioning will form the foundation of the Peer Supported Transitional Housing project and the implementation of it will clearly reduce behavioral health/substance abuse readmissions.

Outcome Measure Valuation

Approach for Valuing Outcome Measure
This project seeks to provide transitional housing services for 20 people in DY4 and 24 in DY 5. This is a small number of people, but this is a group of people who have multiple hospitalizations and great difficulty maintaining community tenure. Stable living gives provides an opportunity to improve life skills and functioning. This represents a substantial savings when compared to bed day costs for inpatient psychiatric facilities and substantial patient benefit in that it supports a healthy life in the community. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation
We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment

uniformity related to crisis services provided in this non-traditional way. We are able to compare value of service for Therapeutic Foster Care against traditional institutional care. Reunification and family preservation are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these disparate factors.

126844305.3.3	*3.IT 3.8*	**IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rates.**	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.2.1*		
Starting Point/Baseline:	*Baseline TBD in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Program documents and records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 11,470 **Process Milestone 2** [P- 2]: Establish baseline rates Data Source: Health Records, Internal and external Process Milestone 2 Estimated Incentive Payment: $ 11,471 **Process Milestone 3** [P- 3] Develop and test data systems Data Source: EHR, other Health Records internal and external Process Milestone 3 Estimated	**Process Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Program documents and records Process Milestone 3 Estimated Incentive Payment: $35,039 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Program documents including agendas, minutes and reports. Process Milestone 5 Estimated Incentive Payment*:* $35,039	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rates. Baseline TBD in DY 3. Improvement Target: 10% reduction from baseline in behavioral health/substance abuse 30 day readmission rates. Data Source: Instrument: EHR, hospital records, DSHS CARE and CMBHS systems. Outcome Improvement Target 1 Estimated Incentive Payment*:* $77,820	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rates. Baseline TBD in DY 3. Improvement Target: 20% reduction from baseline in behavioral health/substance abuse 30 day readmission rates. Data Source: Instrument: EHR, hospital records, DSHS CARE and CMBHS systems. Outcome Improvement Target 2 Estimated Incentive Payment*:* $220,950

126844305.3.3	*3.IT 3.8*	**IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rates.**	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.2.1*		
Starting Point/Baseline:	*Baseline TBD in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Incentive Payment: $11,471			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $34,412	Year 3 Estimated Outcome Amount: $70,078	Year 4 Estimated Outcome Amount: $77,820	Year 5 Estimated Outcome Amount: $220,950
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $403,260			

Title of Outcome Measure (Improvement Target): **IT 9.2 ED appropriate utilization**

Unique RHP Outcome Identification Number: **126844305.3.5 Pass 2**

Performing Provider Name: **Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services**

Performing Provider TPI: **126844305**

Outcome Measure Description

Overall Outcome Measure Description
OD-9 Right Care, Right Setting
IT-9.2 ED appropriate utilization

Process Milestones for Each Year

DY 2: P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3: P- 2 Establish baseline rates
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-9.2 ED appropriate utilization
DY 5: IT-9.2 ED appropriate utilization

Related Category 1 and Category 2 Unique RHP Project Identifiers

126844305.2.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
DY 2 will be a short year with only 6 months to perform, but important to engage stakeholders, achieve community consensus concerning timelines, location of homes and expectations related to providing these new and innovative services in community settings. We will put our efforts into engagement and development.
DY 3 presents the opportunity to identify and refine data sources and establish the baseline for ED visits by those with IDD. As stated in the Narrative for Category 2 related project, 1268443-05.2.2, the detail related to IDD utilization of ED is not currently available through EHRs. It will be necessary to spend time with health systems to define the data and refine how to capture and report it.
The Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help persons with IDD to resolve behavioral crises and return to their long-term

placements in the community. The project will improve appropriate utilization of EDs by this targeted population.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
We plan to develop agreements with health care systems operating EDs in the four counties to allow sharing of admission data related to persons with IDD accessing the EDs. We will also request access to the EDs by the ACT team that will allow for intervention, consultation and collection of data related to characteristics of those persons with respect to behavior issues and mental illness. We will collect data to establish the baseline to be used for the outcome improvement targets in DYs 4 and 5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The goals stated for the related Category 2 Project are to establish an ACT Team that can respond and intervene to improve functioning during a crisis event. We expect the Team to specialize in the assessment and stabilization of persons with IDD throughout the four Counties that we serve in RHP 7. We expect the Team to provide training to law enforcement, emergency room personnel, health care providers, psychiatric hospital providers, and community residential and non-residential providers regarding how to recognize behavioral issues in persons with IDD and how to access appropriate services. When the goals are achieved the participants and the community is informed and engaged, then these community-based interventions will help people to avoid unnecessary loss of community living arrangements and overuse of institutional care. When persons with IDD receive the proper care and interventions, then admissions to institutional care and multiple visits to EDs are avoided.

Outcome Measure Valuation

Approach for Valuing Outcome Measure
We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve regain their functioning level and return to community living. This reduces inappropriate use of inpatient hospital and is of substantial benefit to the patient who can remain in a community living setting. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation
We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to crisis services provided in a new and innovative way to a population which is

generally not addressed well in the community. We are able to compare value with crisis services to the mental health population.

126844305.3.5	*3.IT 9.2*	*ED appropriate utilization*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Program Documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,528	**Process Milestone 2: P- 2 Establish baseline rates** **Data Source:** Local Hospital, local MH authority, EHR and state MH data system records Process Milestone 2 Estimated Incentive Payment: $28,672	**Outcome Improvement Target 1: [IT-9.2]: ED Appropriate Utilization, reduce ED visits by persons with IDD.** **Improvement Target: TBD depending on baseline established during DY 3.** **Data Source: EHR,** Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,625	**Outcome Improvement Target 2: [IT-9.2]: ED Appropriate Utilization, reduce ED visits by persons with IDD.** **Improvement Target: TBD depending on baseline established during DY 3.** **Data Source: EHR,** Outcome Improvement Target 2 Estimated Incentive Payment*:* $66,622
Year 2 Estimated Outcome Amount: : $12,528	Year 3 Estimated Outcome Amount: $28,672	Year 4 Estimated Outcome Amount: $30,625	Year 5 Estimated Outcome Amount: $66,622
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $138,447			

Title of 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: 126844305.3.6 Pass 2

Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services

Performing Provider TPI: **126844305**

Outcome Measure Description

Overall Outcome Measure Description
OD-9 Right Care, Right Setting
IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
Process Milestones for Each Year
DY 2:
P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3:
P- 2 Establish baseline rates
P-3 Develop and test data systems
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:
DY 2: N/A
DY 3: N/A
DY 4: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings.
DY 5: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings.

Related Category 1 and Category 2 Unique RHP Project Identifiers

126844305.2.3

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
We selected project planning and stakeholder engagement as the Process Milestones for DY2 because although we currently provide some services to justice-involved adults and youth, we are proposing to expand geographic availability and to expand eligible program participants. Process Milestones in Category 2 for DY 2 includes, "Conduct needs assessment to identify expanded population of youth and adults who are frequently admitted to criminal justice settings." That Process Milestone differs from this one in that our focus is the engagement of community stakeholders who will be essential to achieving

utilization of the program. We need to carry out the processes to achieve community buy in, utilization of the program and thorough review and assessment of interventions needed. We selected establishing baseline in DY 3 because we do not have the rates of admission and readmission to adult and youth criminal justice settings for this expanded population and we need a year of operation to establish the number served. We also selected developing and testing data systems because we will also need time to gather additional juvenile justice system data concerning the number referred for mental health services in order to measure our Improvement Target.

The Outcome Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help adults and youth successfully return to family and community. Unfortunately lack of behavioral health resources has led to the adult justice system and juvenile justice system providing care rather than having that care provided in the community. However, the justice system is complex and just the availability of care does not guarantee access and use. This program provides assessment, treatment planning and referral to the services as well as linkage between the justice system and the services. The project will also decrease the number of admissions and readmissions to the criminal justice system due to providing diversion and by providing community care to prevent recidivism.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The Outcome Measure is to provide the Right Care in The Right Setting and thereby decrease mental health admissions and readmissions to criminal justice settings. It is our goal to implement this project and improve individual lives and the health and well-being of the communities we serve. Providing community care at the right time and in the right setting and thereby reducing inappropriate arrest and incarceration will lead to productive and contributing youth and adults. We believe that achieving the project goal and providing early intervention and treatment leads directly to the outcome of right care, right setting. Allowing people to languish in jail due to mental illness or substance abuse is wrong and counterproductive for them and for our society. Providing this expanded alternative gives us the opportunity to achieve this Outcome while strengthening the resources available to adults, youth and families in the community.

Outcome Measure Valuation

Approach for Valuing Outcome Measure
We expect to serve an additional 100 people in DY4 and 150 in DY5. The This valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will

be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to clinical services as they are applied in the non-forensic population and applied specifically for those with admissions and readmissions to criminal justice settings. The case management and justice system linkage and coordination are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these factors.

126844305.3.6	*3.IT 9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Service			*126844305*
Related Category 1 or 2 Projects:	*126844305.2.3*		
Starting Point/Baseline:	*Baseline for DY 2 is 0. Will begin enrollment in DY 2 to establish census baseline; establish admission and readmission baseline in DY 3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project documentation, implementation action plans, agendas and minutes Process Milestone 1 Estimated Incentive Payment (maximum amount): $11,039	**Process Milestone 2 [P-2]:** Establish baseline rates. Data Source: Program documentation, justice system documentation and EHR. Process Milestone 2 Estimated Incentive Payment: $ 12,631 **Process Milestone 3 [P-3]:** Develop and test data systems Data Source: Program documentation, justice system documentation and EHR. Process Milestone 3 Estimated Incentive Payment: $ 12,632	**Outcome Improvement Target 1 [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons** Baseline TBD in DY 3 Improvement Target: 10% reduction for both adults and youth. Data Source: Justice system assessments and records; EHR. Outcome Improvement Target 1 Estimated Incentive Payment: $26,984	**Outcome Improvement Target 2 [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons** **Baseline TBD in DY 3** Improvement Target: 25% reduction for both adults and youth. Data Source: Justice system assessments and records; EHR. Outcome Improvement Target 2 Estimated Incentive Payment: $58,701
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $11,039	Year 3 Estimated Outcome Amount: $25,263	Year 4 Estimated Outcome Amount: $26,984	Year 5 Estimated Outcome Amount: $58,701

126844305.3.6	*3.IT 9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Service			*126844305*
Related Category 1 or 2 Projects:	*126844305.2.3*		
Starting Point/Baseline:	*Baseline for DY 2 is 0. Will begin enrollment in DY 2 to establish census baseline; establish admission and readmission 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $121,987			

Title of Outcome Measure (Improvement Target): *IT – 1.8 Depression management: Screening and Treatment Plan for Clinical Depression*

Unique RHP Outcome Identification Number: 126844305.3.7 Pass 2

Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services

Performing Provider TPI: **126844305**

Outcome Measure Description

Overall Outcome Measure Description
OD-1- Primary Care and Chronic Disease Management
IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression

Process Milestones for Each Year
DY 2:
P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3:
P- 2 Establish baseline rates
P-3 Develop and test data systems

Outcome Improvement Targets for Each Year:

DY 4: IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression.
DY 5: IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression

Related Category 1 and Category 2 Unique RHP Project Identifiers

126844305.2.4

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
We selected project planning and stakeholder engagement as the Process Milestones for DY2 because although we currently provide some services in Lockhart to priority population mental health clients, we are establishing an integrated clinic operated by two organizations and treating patients for all behavioral health disorders and providing primary care, pediatrics, Ob/Gyn services and Dental. This new clinic will require stakeholder input and careful implementation planning. We need to carry out the processes to achieve community buy in, utilization of the program and thorough review and assessment of interventions needed. We selected establishing baseline in DY 3 because a new set of services for this expanded population and we need a year of operation to establish the number served. We also selected developing and testing data systems because we will also need time to gather additional expertise as we

continue to integrate EHRs and develop processes for systematic depression screening to measure the Improvement Target.

The Outcome Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting have been suboptimal. Studies have shown that usual care by primary care physicians fails to recognize 30% to 50% of depressed patients. Because patients in whom depression goes unrecognized cannot be appropriately treated, systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression. Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up. We plan to systematically screen individuals and implement treatment in this integrated site.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The Outcome Measure is Depression Management: screening and treatment planning. Integrated health care is a process of eliminating gaps in shared information and communication. We believe that integrated care is more than the physical location or co-location of primary care, behavioral health and other specialty services. It refers to the delivery of comprehensive, coordinated services with good communication among providers. However, without constant work on communication and provider training, systematic depression screening usually does not take place. Additionally, there must be qualified providers to provide treatment planning and then to carry it out in partnership with the patient. Patient involvement is a key to treatment. Integrated health care provides a high quality, multidisciplinary approach to delivering patient-centered services in a cost effective manner. Depression screening and treatment planning are just one component of well-coordinated care as the integrated clinic becomes the patient's medical home

Outcome Measure Valuation

Approach for Valuing Outcome Measure
This project seeks to establish this new integrated healthcare site and serve 3,000 in DY 4 and 4,000 in DY 5. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to clinical services as they are applied in the non-forensic population and applied specifically for those with admissions and readmissions to criminal justice settings. The case management and justice system linkage and coordination are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these factors.

126844305.3.7	*3.IT 1.8*	*Depression management: Screening and Treatment Plan for Clinical Depression*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.2.4*		
Starting Point/Baseline:	*Baseline for DY 2 is 0.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project documentation, implementation action plans, agendas and minutes Process Milestone 1 Estimated Incentive Payment (maximum amount): $108,570	**Process Milestone 2 [P-2]:** Establish baseline rates. Data Source: Program documentation, depression screenings and EHR. Process Milestone 2 Estimated Incentive Payment: $ 124,289 **Process Milestone 3 [P-3]:** Develop and test data systems Data Source: Program documentation, depression screenings and EHR. Process Milestone 3 Estimated Incentive Payment: $ 124,288	**Outcome Improvement Target 1 [IT-1.8]: Depression management: Screening and Treatment Plan for Clinical Depression** Improvement Target: 30% of eligible patients 18 and older receive a depression screening at least once per year and treatment plan if applicable Data Source: EHR, Claims and Depression screenings Outcome Improvement Target 1 Estimated Incentive Payment: $265,403	**Outcome Improvement Target 2 [IT-1.8]: Depression management: Screening and Treatment Plan for Clinical Depression** Improvement Target: 50% of eligible patients 18 and older receive a depression screening at least once per year and treatment plan if applicable Data Source: EHR, Claims and Depression screenings Outcome Improvement Target 2 Estimated Incentive Payment: $577,361
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $108,570	Year 3 Estimated Outcome Amount: $248,477	Year 4 Estimated Outcome Amount: $265,403	Year 5 Estimated Outcome Amount: $577,361
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,199,811			

CATEGORY 3 OUTCOME MEASURE NARRATIVE

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): *IT – 1.9 Depression management: Depression Remission at Twelve Months*

Unique RHP Outcome Identification Number: 126844305.3.8 Pass 2

Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services

Performing Provider TPI: **126844305**

Outcome Measure Description

Overall Outcome Measure Description
OD-1- Primary Care and Chronic Disease Management
IT-1.9 Depression management: Depression Remission at Twelve Months ***Process Milestones for Each Year***
DY 2:
P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3:
P- 2 Establish baseline rates
P-3 Develop and test data systems

Outcome Improvement Targets for Each Year:

DY 4: IT-1.9 Depression management: Depression Remission at Twelve Months

DY 5: IT-1.9 Depression management: Depression Remission at Twelve Months

Related Category 1 and Category 2 Unique RHP Project Identifiers

126844305.2.4

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
We selected project planning and stakeholder engagement as the Process Milestones for DY2 because although we currently provide some services in Lockhart to priority population mental health clients, we are establishing an integrated clinic operated by two organizations and treating patients for all behavioral health disorders and providing primary care, pediatrics, Ob/Gyn services and Dental. This new clinic will require stakeholder input and careful implementation planning. We need to carry out the processes to achieve community buy in, utilization of the program and thorough review and assessment of

interventions needed. We selected establishing baseline in DY 3 because a new set of services for this expanded population and we need a year of operation to establish the number served. We also selected developing and testing data systems because we will also need time to gather additional expertise as we continue to integrate EHRs and develop processes for systematic depression screening to measure the Improvement Target.

The Outcome Improvement Target for DY 4 and 5 is a stand-alone measure. We selected this measure because we are working toward making our integrated clinic sites true collaborative care clinics. By establishing our services together and managing them together we believe we can achieve system changes that help ensure adequate treatment and follow-up. As we initiate systematic screening we will also initiate follow up screening protocols to determine treatment efficacy. This outcome should result from the system changes and treatment in this integrated site. This Outcome Improvement Target will document that result.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The Outcome Measure is 'Depression management: Depression Remission at Twelve Months.' Integrated health care is a process of eliminating gaps in shared information and communication. We believe that integrated care is more than the physical location or co-location of primary care, behavioral health and other specialty services. It refers to the delivery of comprehensive, coordinated services with good communication among providers. However, without constant work on communication and provider training, adequate treatment and follow-up usually does not take place. Additionally, there must be qualified providers to provide treatment planning and then to carry it out in partnership with the patient. Patient involvement is a key to treatment. Integrated health care provides a high quality, multidisciplinary approach to delivering patient-centered services in a cost effective manner. Depression screening and treatment planning are just one component of well-coordinated care as the integrated clinic becomes the patient's medical home

Outcome Measure Valuation

Approach for Valuing Outcome Measure
This project seeks to establish this new integrated healthcare site and serve 3,000 in DY 4 and 4,000 in DY 5. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included called quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). A description of the method used, titled 'Valuing Transformation Projects,' has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Rationale/Justification for Valuation

We adopted this approach in order to value projects through a uniform method despite having very different outputs and processes. We believe that for this particular project, it contributes to assessment uniformity related to clinical services as they are applied in the non-forensic population and applied specifically for those with admissions and readmissions to criminal justice settings. The case management and justice system linkage and coordination are key elements that are difficult to compare to value of reduced system health care costs and specific health system benefits. This allows us to compare these factors.

126844305.3.8	*3.IT 1.9*	*Depression management: Depression Remission at Twelve Months*	
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services			*126844305*
Related Category 1 or 2 Projects:	*126844305.2.4*		
Starting Point/Baseline:	*Baseline for DY 2 is 0.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project documentation, implementation action plans, agendas and minutes Process Milestone 1 Estimated Incentive Payment (maximum amount): $108,569	**Process Milestone 2 [P-2]:** Establish baseline rates. Data Source: Program documentation, depression scales and EHR. Process Milestone 2 Estimated Incentive Payment: $ 124,289 **Process Milestone 3 [P-3]:** Develop and test data systems Data Source: Program documentation, depressions scales and EHR. Process Milestone 3 Estimated Incentive Payment: $ 124,288	**Outcome Improvement Target 1 [IT-1.9]: Depression management: Depression Remission at Twelve Months** Improvement Target: 20% of patients diagnosed and treated for depression, improve on depression scale at 12 months. Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 1 Estimated Incentive Payment: $265,403	**Outcome Improvement Target 2 [IT-1.9]: Depression management: Depression Remission at Twelve Months** Improvement Target: 30% of patients diagnosed and treated for depression, improve on depression scale at 12 months Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 2 Estimated Incentive Payment: $577,360
Year 2 Estimated Outcome Amount: $108,569	Year 3 Estimated Outcome Amount: $248,477	Year 4 Estimated Outcome Amount: $265,403	Year 5 Estimated Outcome Amount: $577,360
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,199,809			

Central Texas Medical Center (CTMC)
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): IT – 9.2: ED Appropriate Utilization

Unique RHP Outcome Identification Number: 121789503.3.1Pass 1

Performing Provider Name: Central Texas Medical Center

Performing Provider TPI: 121789503

Outcome Measure Description

Overall Outcome Measure Description: The goal of this project is to reduce hospital emergency department utilization of targeted population. (IT-9.2).

Process Milestones for Each Year

DY 2: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
Develop data systems to capture ED utilization of target population.
DY 3: Test data systems to capture Ed utilization of target population.
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: TBD fewer ED visits in DY4.
DY 5: TBD fewer ED visits in DY5.

Related Category 1 and Category 2 Unique RHP Project Identifiers

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets DY 2 and DY3 will focus on evaluating the current clinic infrastructure, identifying current capacity, needed resources (including additional providers), optimum hours that will enhance patient access, timelines and development of a complete implementation plan. Such planning is necessary to optimize current resources and determine what additional resources are needed to meet the pre-determined outcome improvement target of reduced ED utilization. Additionally, systems to capture current ED utilization of the target populations and future utilization will be necessary in order to quantify achievement of the improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3. During DY2 and DY3 baseline ED utilization data will be captured in order to establish specific improvement targets in DY 4 and DY5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
In Hays County, low-income, uninsured adult residents have limited or few options for accessing primary care services. This places a significant burden on hospital emergency departments within the County and the RHP. The creation and expansion of the Central Texas Healthcare Collaborative clinic will increase accessibility to primary care services, reduce wait times and delayed care, increase patient satisfaction, create timely access for follow-up visits, better manage chronic and/or complex diseases and reduce reliance on emergency departments for primary care. This promotes the right care, at the right time, in the right place.

Outcome Measure Valuation

Approach for Valuing Outcome Measure: Establishing a medical home for this at-risk population, reduces health system costs by expanding opportunities for patients to access the most appropriate care in the most appropriate setting. The expected core value of this project is to reduce reliance on high cost emergency department interventions for non-urgent services thus preserving this resource for true crises care. Promoting accessible, coordinated and consistent outpatient healthcare services will lessen the potential for individuals to forego care or delay care which can lead to avoidable complications. A secondary value is better long-term management of chronic and/or complex disease processes that can reduce potentially avoidable hospital admissions and re-admissions. This will be accomplished through clinic referrals to area specialists, access to prescriptions and outpatient diagnostic services.

Rationale/Justification for Valuation: Considerations for valuing this project include cost avoidance e.g. potentially preventable admissions/re-admissions, ED utilization for non-urgent care, and the size of the target population.

121789503.3.1	***3.IT-9.2***	***ED Appropriate Utilization***	
[Central Texas Medical Center]			*[121789503]*
Related Category 1 or 2 Projects:	*[121789503.1.1]*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: [Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.] Data Source: Clinic Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $170,250 **Process Milestone 2** [P-3]: Develop data systems to capture ED utilization of target population. Data Source: Clinic Documentation Process Milestone 2 Estimated Incentive Payment: $170,250	**Process Milestone 3** [P-3]: Test data systems to capture ED utilization of target population. Data Source: Clinic Documentation Process Milestone 3 Estimated Incentive Payment: $380,500	**Outcome Improvement Target 1** [IT-9.2]: Improvement Target: TBD fewer ED visits in DY4. Data Source: electronic health record (EHR) and/or regional health information exchange (HIE) data Outcome Improvement Target 2 Estimated Incentive Payment*:* $626,250	**Outcome Improvement Target 2** [IT-9.2]: Improvement Target: TBD fewer ED visits in DY5. Data Source: electronic health record (EHR) and/or regional health information exchange (HIE) data Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,509,750

121789503.3.1	***3.IT-9.2***	***ED Appropriate Utilization***	
[Central Texas Medical Center]			*[121789503]*
Related Category 1 or 2 Projects:	*[121789503.1.1]*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $340,500	Year 3 Estimated Outcome Amount: $380,500	Year 4 Estimated Outcome Amount: $626,250	Year 5 Estimated Outcome Amount: $1,509,750
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,857,000			

City of Austin HHSD
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): ED Appropriate Utilization

Unique RHP Outcome Identification Number: 201320302.3.1 Pass 1

Performing Provider Name: City of Austin HHSD

Performing Provider TPI: 201320302

Outcome Measure Description

Overall Outcome Measure Description
OD- 9 Right Care, Right Setting

Process Milestones for Each Year
DY 2: P-1. Project planning
DY 3: P- 2 Establish baseline rates
DY 4: P- 3 Develop and test data systems

Outcome Improvement Targets for Each Year:
DY 4: IT-9.2 Reduce Emergency Department visits for target conditions
- Behavioral Health/Substance Abuse

DY 5: IT-9.2 Reduce Emergency Department visits for target conditions
- Behavioral Health/Substance Abuse

Related Category 1 and Category 2 Unique RHP Project Identifiers
City of Austin
2.13.1 HF ACT PSH

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

P-1 (Project planning) in DY 2 was selected because we anticipate that the first year will consist of engaging stakeholders, identifying current capacity and needed resources, as well as determining timelines and document implementation plans. P-2 (Establish baseline data) in DY 3 was selected because a baseline rate will need to be established in order to move forward with project development. P-3 (Develop and test data systems) was selected for DY 4 because a data system will need to be tested and implemented once the project has been planned and the baseline data has been established. We chose IT-9.2 (Reduce Emergency Department visits for target conditions) because we anticipate that participants will utilize the ED's less, and thus more appropriately, once they have been enrolled in the DSRIP project, have established a routine with their ACT team members, and have learned how to manage their medications. Also, by DY 5, the data and systems will be in place in order to track this population's use of EDs.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

NA

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

OD- 9 (Right Care, Right Setting) and IT-9.2 (Reduce Emergency Department visits for target conditions) were selected because we feel that our Category 2 project outcome improvement measure I-4 (Anti-Depressant medication management over six months for Major Depressive Disorder and anti-depressant medication during acute phase over 12 weeks), will help achieve better ED utilization rates because project participants will no longer need to use the ED as their primary health care system if they are better able to manage and maintain their Anti-Depressant medication. Specifically, I-4 was selected because we know from Dr. Stone's data that 31% of homeless people who frequent the ED four or more times in 30 days suffer from major depression[138].

Additionally, these outcome measures were chosen because the target population for this DSRIP project are former chronically homeless men and women with BH issues, who often frequent the ED for non-emergency reasons. However, once they are connected with an ACT team and are stabilized in their HF PSH units, they can focus on routine and preventative care at their PCP, thus reducing their admission to the ED. In addition to having the ACT team available to provide answers and referrals, resolve disputes, and assist with medication management, etc, just having safe and secure housing will allow these individuals to recover in their own homes, rather than allowing a situation to progress to the point of emergency.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

Because this population is often uninsured, yet uses the costliest emergency services, there will be a cost avoidance/savings once these high frequent service users are connected to housing and an ACT team. For example, in just three months in 2011, 367 frequent users of EMS (many of whom were or are homeless) requested 6,567 ambulances. During this same time, the top 10 users requested emergency medical transport 831 times. Each of these ambulance visits cost approximately $160, not including unpaid medical bills, which averaged $970 per call[139]. Therefore, by connecting individuals to appropriate medical care, there will be a decreased use of expensive emergency services by uninsured individuals, resulting in cost avoidance/savings to the community at large. Our approach incorporated the overall valuation of our Category 2 project as well as the value to the community in implementing this project.

Rationale/Justification for Valuation

This project was partially valued using ER cost avoidance data.[140] This approach best represents the investment of the performing provider and the community as a whole.

[1,2] "Frequent Utilization of Behavioral Health Services in Various Service Systems", Presented by Mental health Task Force in August 2011

[139] Roser, M. A. (2011, July 5). Austin-Travis County EMS aims to match habitual 911 callers to social services. The Austin American-Statesman.

201320302.3.1	IT-9.2	*ED Appropriate Utilization*	
City of Austin HHSD			201320302
Related Category 1 or 2 Projects:	201320302.2.1		
Starting Point/Baseline:	*0 People in HF ACT PSH; A new baseline 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-1. Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project documents and meeting minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,500 (5%)	**Process Milestone 2** P- 2 Establish baseline rates Data Source: EMS reports and participant interviews and intake forms Process Milestone 2 Estimated Incentive Payment: $ 25,000	**Process Milestone 3**: P-3. Develop and test data systems Data Source: Homeless Management Information System (HMIS), creation of MOUs with EMS and hospitals Process Milestone 3 Estimated Incentive Payment: $37,500 **Outcome Improvement Target 1** IT-9.2:ED Appropriate Utilization Improvement Target: 15% improvement in Year 4 Data Source: EMS and hospital reports and data, Integrated Care Collaboration[141], ACT team reports	**Outcome Improvement Target 2** IT-9.2: ED Appropriate Utilization Improvement Target: 20% improvement in year 5 Data Source: EMS and hospital reports and data, Integrated Care Collaboration[142] ACT team reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $50,000

[3,4] http://icc-centex.org/ The ICC is a nonprofit alliance of health care providers in Central Texas dedicated to the collection, analysis and sharing of health information with the goal of improving health care quality and cost efficiency across the continuum of care.

201320302.3.1	IT-9.2	*ED Appropriate Utilization*	
City of Austin HHSD			201320302
Related Category 1 or 2 Projects:	201320302.2.1		
Starting Point/Baseline:	*0 People in HF ACT PSH; A new baseline 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)**
		Outcome Improvement Target 1 Estimated Incentive Payment: $37,500	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $12,500	Year 3 Estimated Outcome Amount: $ 25,000	Year 4 Estimated Outcome Amount: $37,500	Year 5 Estimated Outcome Amount: $50,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $125,000			

Title of Outcome Measure (Improvement Target): 10.1: Quality of Life /Functional Status
Unique RHP Outcome Identification Number: 201320302.3.2 Pass 1
Performing Provider Name: **City of Austin Health and Human Services Department**
Performing Provider TPI/TIN: 201320302

Outcome Measure Description

Overall Outcome Measure Description

The project proposes to measure the impact of Diabetes Self Management Education provided through a Community Health Worker model. Pre and Post Quality of Life assessments that are validated for persons with diabetes will be implemented for each DSME class series.

Process Milestones for Each Year

DY 2: P.1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P.2 Establish baseline quality of life measures for persons with diabetes in the target population

DY 3: P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

DY 4: P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

DY 5: P.5 Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: Quality of Life assessments demonstrate a 3% improvement on one or more quality of life measures.

DY 5: Quality of Life assessments demonstrate a 5% improvement on one or more quality of life measures.

Related Category 1 and Category 2 Unique RHP Project Identifiers

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The process milestones will document the stakeholder engagement and involvement, ensure an appropriate baseline is established which will define the target population and evaluation steps to ensure an effective program is implemented.
The outcome measure selected will demonstrate the impact of implementing evidence-based diabetes self-management education on quality of life. Disease management and maintaining good diabetes control is directly related to a person's quality of life and is a predictor of improved health outcomes. [143] Additionally, disease management and self-care training has been shown to improve quality of life. [144]

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

ATCHHSD selected project option 2.6.2 Establish self-management programs and wellness using evidence-based designs. This proposed project would utilize an evidence-based curricula for diabetes self-management education designed for implementation by Community Health Workers. As a result, the project will focus on improving quality of life through assessments that are validated for persons with diabetes. Diabetes self-management education has been shown to improve quality of life and is a predictor of improved diabetes compliance and health outcomes.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

The valuation is based on estimated impact of DSME classes provided by CHWs on health care costs. ATCHHSD estimates that the value of the service is double that of every dollar spent.

Rationale/Justification for Valuation
Services provided by CHW's have been shown to reduce health care costs yielding at least a 2 dollar savings for every dollar spent.[145] Additionally, a study by Brown et al found that a lifestyle modification program led by community health workers for low income Hispanic adults with type 2 diabetes had an incremental cost effectiveness ratio that ranged from $10,9995 to $33,319 per quality of life years gained when compared to usual care.[146]

Additionally, according to JAMA, studies have demonstrated that a 1% reduction in HbA1c suggests health care cost savings of approximately $400 to $4000 per patient over the ensuing 3 years, with the savings increasing with the level of baseline HbA1c and the presence of vascular diseases. This project has the potential to reduce $1,600,000 per year in health care costs.

[143] http://journal.diabetes.org/diabetesspectrum/00v13n1/pg21.htm
[144] http://www.ncbi.nlm.nih.gov/pubmed/18832286
[145] http://www.ncbi.nlm.nih.gov/pubmed/16520499

[146] http://www.cdc.gov/pcd/issues/2012/12_0074.htm

201320302.3.2	*3.IT10.1*	*Quality of Life improvement through Community Health Worker Model DSME*	
City of Austin Health and Human Services			N/A
Related Category 1 or 2 Projects:	201320302.2.2		
Starting Point/Baseline:	TBD		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 P.1 Project **planning**-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Performing Provider program data Process Milestone 1Estimated Incentive Payment: $5,000 **Process Milestone 2: P.2** Establish baseline quality of life measures for persons with diabetes Data Source: Performing Provider program data	**Process Milestone 3-**P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Performing Provider Program Data Process Milestone 3: Estimated Incentive Payment: $60,000	**Process Milestone 4-**P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Performing Provider Program Data Process Milestone 4: Estimated Incentive Payment: $30,000 **Outcome Improvement Target 1** [IT-10.1]: Quality of Life (Standalone measure) Improvement Target: Demonstrate improvement in quality of life scores, as measured by evidence base and validates assessment tool for the	**Process Milestone 5** P.5 Disseminate finding, including lessons learned and best practices to stakeholders Data Source: Performing Provider program data Process Milestone 5 Estimated Incentive Payment: $60,000 **Outcome Improvement Target 2** [IT-10.1]: Quality of Life (Standalone measure) Improvement Target: Demonstrate improvement in quality of life scores, as measured by evidence base and validates assessment tool for the target population. Improvement Target: Quality of

201320302.3.2	*3.IT10.1*	*Quality of Life improvement through Community Health Worker Model DSME*	
City of Austin Health and Human Services			N/A
Related Category 1 or 2 Projects:	201320302.2.2		
Starting Point/Baseline:	TBD		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $5,000		target population. Improvement Target: Quality of Life assessments demonstrate a 3% improvement on one or more quality of life measures among individuals receiving intervention. Data Source: validated diabetes quality of life questionnaire Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,000	Life assessments demonstrate a 5% improvement on one or more quality of life measures among individuals receiving intervention. Data Source: validated diabetes quality of life questionnaire Outcome Improvement Target 2 Estimated Incentive Payment*:* $60,000
Year 2 Estimated Outcome Amount:: $10,000	Year 3 Estimated Outcome Amount: $60,000	Year 4 Estimated Outcome Amount: $60,000	Year 5 Estimated Outcome Amount: $120,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $250,000			

Title of Outcome Measure (Improvement Target): Primary Care and Primary Prevention: IT-12.6 Other Outcome Improvement Target: Adult Current Smoking Prevalence among 18-24 year olds

Unique RHP Outcome Identification Number: 201320302.3.3 Pass 1

Performing Provider Name: **City of Austin Health and Human Services Department**

Performing Provider TPI: 201320302

Outcome Measure Description

Overall Outcome Measure Description

Outcome Domain-12 Primary Care and Primary Prevention
IT-12.6 Other Outcome Improvement Target: Adult Current Smoking Prevalence. The selected outcome improvement target was endorsed by National Quality Forum as a Cancer Population Health Measure on October 24, 2012.[147]

This indicator has also been identified nationally by the Health and Human Services Health Indicators Warehouse and Healthy People 2020.[148]

Process Milestones for Each Year

DY 2: P.1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P.2 Establish baseline smoking prevalence rates for 18-24 year olds in Travis County.

DY 3: P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

P.5 Disseminate finding, including lessons learned and best practices to stakeholders

P.3 Develop and test data systems

DY 4: P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

DY 5: P.5 Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets for Each Year:

DY 4: IT-11.6 Other Outcomes Improvement Target - Adult Current Smoking Prevalence: Reduce tobacco use among the 18-24 year old population in Travis County by 3%.

[147] http://www.beckershospitalreview.com/quality/nqf-endorses-cancer-population-health-measures.html
[148] http://www.healthindicators.gov/Indicators/Cigarettesmoking-Adults(aged18yearsandover)_1498/Profile/Data

DY 5: IT-11.6 Other Outcomes Improvement Target - Adult Current Smoking Prevalence: Reduce tobacco use among the 18-24 year old population in Travis County by 5%.

Related Category 1 and Category 2 Unique RHP Project Identifiers
201320302.*2.3*

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The process milestones will document stakeholder engagement and involvement, ensure an appropriate baseline is established, and document evaluation steps to ensure an effective program is implemented.

The outcome measure selected will demonstrate the impact of implementing evidence-based strategies to reduce smoking among the 18-24 year old population. ATCHHSD selected the target age group of 18-24 year olds for this proposal because more than 80% of adult smokers begin smoking by 18 years of age with 99% of first use by 26 years of age. Addressing young adult smoking is important because cessation before age 30 avoids almost all the long-term effects of smoking.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Evidence based promotion of tobacco cessation resources through mass media, grassroots outreach, health care provider referrals, and making cessation services available where tobacco-free campuses are being implemented will assist in achieving this outcome measure.

Outcome Measure Valuation

Approach for Valuing Outcome Measure
The project valuation is based on the number of 18-24 year old persons that call the Texas Quitline or other cessation services which is a conservative estimate considering that we know many others will quit but may not utilize the quitline as a result of this intervention ATCHHSD estimates a value of $3,388 per person utilizing cessation services. ATCHHSD estimates that 150 persons who are 18-24 year will access tobacco cessation services, which has the potential to produce a savings of $508,200 annually. The intervention will have an impact on the overall community and will increase quitline callers from the general population by 50 persons which has the potential to produce an additional savings of $169,400 annually. Total number of persons served over the project period is 800 producing a total savings of 2,710,400.

Rationale/Justification for Valuation
According to the CDC, cigarette smoking costs more than $193 billion (i.e., $97 billion in lost productivity plus $96 billion in health care expenditures). Secondhand smoke costs more than $10 billion (i.e., health care expenditures, morbidity, and mortality). This project proposes a tobacco program funded at $3 per person. Studies have shown this to be effective in reducing smoking. As a result, long term savings will be

achieved.[149] According to the Estimated Smoking-Attributable Mortality and Economic Costs in Austin for 2007, costs of smoking due to loss of productivity ($1372 per person) and personal health care costs ($2016 per person) total $3,388 per person who smokes. Our estimated valuation of $677,600 per year as noted above, is conservative as we anticipate that implementation of the project proposal will result in an overall 5% reduction in smoking among the estimated 31,878 18-24 year old smokers which over 5 years would lead to a $3,388,000 estimated reduction in health care costs and lost productivity.

The U.S. Public Health Service's recently updated clinical practice guidelines found that quitline counseling can more than double a smoker's chances of quitting. Quitline counseling combined with medication (such as nicotine replacement therapy) can more than triple the chances of quitting.[4]

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[149] Settlement-Funded Tobacco Control in Texas: 2000- 2004 Pilot Project Effects on Cigarette Smoking. Public Health Reports. 2006 May-June;121, 235-238.

[4] Fiore, MC, et al., *Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline*, U.S. Public Health Service, May 2008, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.

201320302.3.3	*3 IT 12.6*	Primary Care and Primary Prevention: IT-12.6 Other Outcome Improvement Target: Smoking Prevalence among 18-24 year olds	
City of Austin Health and Human Services			201320302
Related Category 1 or 2 Projects:	201320302*.2.3*		
Starting Point/Baseline:	Baseline will be established in Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1: P.1 Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Performing Provider program data Process Milestone 1Estimated Incentive Payment: $15,000 **Process Milestone 2: P.2** Establish baseline smoking prevalence rates for 18-24 year olds in Travis County. Data Source: Performing	**Process Milestone 3:**P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Performing Provider Program Data Process Milestone 3: Estimated Incentive Payment: $23,333.33 **Process Milestone 4:** P.5 Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Performing	**Process Milestone 6:** P.4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Performing Provider Program Data Process Milestone 6 Estimated Incentive Payment: $35,000 **Outcome Improvement Target 1** [IT-12.6]: Other Outcome Improvement Target: Smoking Prevalence among 18-24 year olds in Travis County Improvement Target: 3%	**Process Milestone 7:** P.5 Disseminate findings, including lessons learned and best practices to stakeholders Data Source: Performing Provider Program Data Process Milestone 7 Estimated Incentive Payment: $70,000 **Outcome Improvement Target 2** [IT-12.6]: Other Outcome Improvement Target: Smoking Prevalence among 18-24 year olds in Travis County Improvement Target: 5% reduction of smoking rates among 18-24 year old population

201320302.3.3	*3 IT 12.6*	Primary Care and Primary Prevention: IT-12.6 Other Outcome Improvement Target: Smoking Prevalence among 18-24 year olds	
City of Austin Health and Human Services			201320302
Related Category 1 or 2 Projects:	201320302*.2.3*		
Starting Point/Baseline:	Baseline will be established in Year 2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Provider program data Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $15,000	Provider program data Process Milestone 4 Estimated Incentive Payment: $23,333.33 **Process Milestone 5:** P.3 Develop and test data systems Data Source: Performing Provider program data Process Milestone 5 Estimated Incentive Payment: $23,333.33	reduction of smoking rates among 18-24 year old population Data Source: Behavioral Risk Factor Surveillance System Outcome Improvement Target 1 Estimated Incentive Payment*:* $35,000	Data Source: Behavioral Risk Factor Surveillance System Outcome Improvement Target 1 Estimated Incentive Payment*:* $70,000
Year 2 Estimated Outcome Amount:: $30,000	Year 3 Estimated Outcome Amount: $70,000	Year 4 Estimated Outcome Amount: $70,000	Year 5 Estimated Outcome Amount: $ 140,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $310,000			

Title of Outcome Measure (Improvement Target): **IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382) (Standalone measure)**

Unique RHP Outcome Identification Number: **201320302.3.4**

Performing Provider Name: **CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT (HHSD)**

Performing Provider TPI: **201320302**

Outcome Measure Description

Overall Outcome Measure Description

IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382) *(Standalone measure)*

a. Numerator: The number of babies born weighing <2,500 grams at birth
b. Denominator: All births

Process Milestones for Each Year

DY 2: P-2 Establish baseline rates
DY 3: P- 3 Develop and test data systems
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: IT-8.2 Percentage of low birth-weight births
DY 5: IT-8.2 Percentage of low birth-weight births

Related Category 1 and Category 2 Unique RHP Project Identifiers

201320302.2.4 Pre/Post Natal Program

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The Project intends to provide a connection to pre and postnatal services even though it does not provide the clinical services itself. If successful, participants' outcomes should improve over community outcomes. These outcomes are preferable to others that would be more intermediary.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Outcome improvement target will be determined in DY 3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

- Improving access to and utilization of prenatal care, specifically the timing of the first prenatal visit to be in the first trimester.
- Increase the number of families that have a medical home, including pediatric care
- Reducing the incidence of low and very low birth weights.
- Reducing preterm births.
- Increasing the incidence of breastfeeding.
- Reducing the infant mortality rate.
- Increasing available support systems and knowledge of and connection to community resources during the prenatal, perinatal, and infancy periods.
- Increasing the availability of screenings and moving the timing of screenings to preconception and early pregnancy to identify risk factors in areas such as health, mental health, domestic violence, and social isolation.
- Increased access to parent education during both pregnancy and infancy.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

Because of the wide variety of preventative savings and the difficulty of assigning a cost to a particular individual, an average cost per client is used. Examples of cost savings/offsets are:

- Depending on the population, cost-savings range from $1,768 to $5,560 per infant/mother pair.
- Augmented prenatal care on women at high risk for a low birth weight (LBW) birth…basic prenatal care, prenatal education, and case management…saved $13,961.42 per single LBW birth

http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_cost-offset.pdf

Rationale/Justification for Valuation

Pre and postnatal interventions can prevent or ameliorate a number of complications that can impact the child and family for years and increase costs of health care including the cost of remediation of developmental delays. Other community costs include educational consequences.

201320302.3.4	OD-8 IT-8.2	IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382) (Standalone measure)	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			**201320302**
Related Category 1 or 2 Projects:	**201320302.2.4** - 2.6 Implement Evidence-based Health Promotion Programs		
Starting Point/Baseline:	0 clients (new program)		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2 Establish baseline rates Data Source: Client records and community data reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $23,670	**Process Milestone 2** [P-2]: P- 3 Develop and test data systems • Plan and refine data systems • Outcome data • Program goals data • Include client tracking data • Develop provider relationships and information sharing Data Source: Client records, client reports, provider data Process Milestone 2 Estimated Incentive Payment: $71,010	**Outcome Improvement Target 1** [IT-1.1]: IT-8.2 Percentage of low birth-weight births Improvement Target: 5% less than baseline (estimated subject to revision in DY3) Data Source: Client records, provider data Outcome Improvement Target 1 Estimated Incentive Payment*:* $118,351	**Outcome Improvement Target 2** [IT-1.1]: IT-8.2 Percentage of low birth-weight births Improvement Target: 10% less than baseline (estimated subject to revision in DY3) Data Source: Client records, provider data Outcome Improvement Target 2 Estimated Incentive Payment*:* $157,800
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $23,670	Year 3 Estimated Outcome Amount: $71,010	Year 4 Estimated Outcome Amount: $118,351	Year 5 Estimated Outcome Amount: $157,800
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $370,831			

Title of Outcome Measure (Improvement Target):
OD-11 IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Non-stand alone measure)
Unique RHP Outcome Identification Number: **201320302.3.5 Pass 2**
Performing Provider Name: **CITY OF AUSTIN HEALTH AND HUMAN SERVICES (HHSD)**
Performing Provider TPI: **201320302**

Outcome Measure Description

Overall Outcome Measure Description

IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. (Non-standalone measure)

The outcomes will be tracked for program clients participating in the project.

Process Milestones for Each Year

DY 2: P-2 Establish Baseline Rates and P-4 Plan Do Study Act Cycle
DY 3: P-4 Plan Do Study Act Cycle
DY 4: P-4 Plan Do Study Act Cycle

Outcome Improvement Targets for Each Year:

DY 4: OD-11 IT-11.2 Improvement in disparate health outcomes for target population
DY 5: OD-11 IT-11.2 Improvement in disparate health outcomes for target population

Related Category 1 and Category 2 Unique RHP Project Identifiers

201320302.2.5 Healthy Families

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Process Milestones: A new component for Healthy Families in this Project is the focus on African-American families. A frequent evaluation cycle to reassess and improve the outreach and recruitment and retention of client families will be a critical process in order to make rapid adjustments that improve the efficacy of the Project.

Outcome: The target population, African-Americans, have significant disparities in both child abuse/neglect rates and low birth weight. One of the success indicators of the program will be the reduction of the disparities in the clients served.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Improvement targets will be established in DY 2 as part of the process establishing the baseline in consultation with the Healthy Families staff.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Healthy Families is an evidence-based program that promotes healthy development and prevention of child maltreatment. A combination of home visiting, parenting education, and connections to health services including prevention services works to achieve the goal of healthy development and child abuse/neglect prevention. Serving a higher percentage of African-American families will address the disparity of over representation of African-Americans in the families and children in the protective services system.

Clients served prenatally should have improved birth outcomes due to earlier prenatal care and improved nutrition. Although a small sample, it is expected that expectant parents in the program earlier in pregnancy will have better outcomes than clients with a shorter service period or the community measures.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

The approach recognizes the importance of early childhood development and the critical work of prevention programs in preventing insults to human development. The community also recognizes the disparity of African-Americans involvement with the child protection system and in birth outcomes.

Rationale/Justification for Valuation

Pre and postnatal interventions can prevent or ameliorate a number of complications that can impact the child and family for years and increase costs of health care including the cost of remediation of developmental delays. Other community costs include educational consequences. Some examples are:

- Medicaid enrolled children with up-to-date well child checks through 2 years of age are 48% less likely to experience avoidable hospitalization
- Parental injury prevention counseling saves $2,800 per quality adjusted life year
- Vision and hearing screenings are cost-effective preventative services. "Eye disorders are the most common reason that children become handicapped in the United States"

http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_cost-offset.pdf

The costs of child maltreatment exist in the immediate term due to the treatment costs for the results of injuries and neglect. Long-term costs result from damage that follows victims through childhood and into adulthood including health issues and mental health issues including other insults such as homelessness that can produce additional negative health impacts.

"A new study of the economic burden of child maltreatment in the United States calculated that the lifetime costs of child maltreatment are $210,012 per child in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs. The estimated average lifetime cost per death is $1,272,900, including $14,100 in medical costs and $1,258,800 in productivity losses. The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States in 2008 is approximately $124 billion."

Fang, X., Brown, D.S., Florence, C.S., & Mercy, J.A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect, 36(2), 156-165.

201320302.3.5	IT-11.2	IT-11.2 Improvement in disparate health outcomes for target population	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			***TPI* 201320302**
Related Category 1 or 2 Projects:	**201320302.2.5** 2.7 Implement Evidence-based Disease Prevention Programs, 2.7.6 Other		
Starting Point/Baseline:	TBD in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 P-4 Plan Do Study Act Cycle Identify disparate health outcomes to be tracked Design tracking systems Set study cycle frequency Data Source: Healthy Families planning, activity, evaluation data and documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,652 **Process Milestone 2** P-2 Establish Baseline Rates • Set baselines for tracked outcomes Data Source: Healthy Families and CPS caseworker reports, community data Process Milestone 2 Estimated Incentive Payment: $2,652	**Process Milestone 3** P-4 Plan Do Study Act Cycle • Review available outcome results • Evaluate • Plan improvements Data Source: Healthy Families planning, activity, evaluation data and documentation Process Milestone 3 Estimated Incentive Payment: $15,910	**Process Milestone 4** P-4 Plan Do Study Act Cycle • Review available outcome results • Evaluate • Plan improvements Data Source: Healthy Families planning, activity, evaluation data and documentation Process Milestone 4 Estimated Incentive Payment: $13,258 **Outcome Improvement Target 1** IT-11.2 Improvement in disparate health outcomes for target population Improvement Target: Reduce low birth rate disparity by 5% Data Source: Healthy Families and CPS caseworker reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $13,258	**Outcome Improvement Target 2** IT-11.2 Improvement in disparate health outcomes for target population. Improvement Target: Reduce low birth rate disparity by 5% Data Source: Healthy Families and CPS caseworker reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $35,355
Year 2 Estimated Outcome Amount: $5,304	Year 3 Estimated Outcome Amount: $15,910	Year 4 Estimated Outcome Amount: $26,516	Year 5 Estimated Outcome Amount: $35,355

201320302.3.5	IT-11.2	IT-11.2 Improvement in disparate health outcomes for target population	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			***TPI* 201320302**
Related Category 1 or 2 Projects:	**201320302.2.5** 2.7 Implement Evidence-based Disease Prevention Programs, 2.7.6 Other		
Starting Point/Baseline:	TBD in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $83,085			

Title of Outcome Measure (Improvement Target):
OD-11 IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. *(Non-standalone measure)*
Unique RHP Outcome Identification Number: **201320302.3.6 Pass 2**
Performing Provider Name: **CITY OF AUSTIN HEALTH AND HUMAN SERVICES (HHSD)**

Performing Provider TPI: **201320302**
Outcome Measure Description

Overall Outcome Measure Description
IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure)

a Numerator: TBD by performing provider
b Denominator: TBD by performing provider
c Data Source: TBD by performing provider
d Rationale/Evidence: Rationale to include citation, evidence base and significance of target towards intervention population or community of need

Process Milestones for Each Year

DY 2: P-2 Establish Baseline Rates and P-4 Plan Do Study Act Cycle
DY 3: P-4 Plan Do Study Act Cycle
DY 4: P-4 Plan Do Study Act Cycle
:

Outcome Improvement Targets for Each Year:

DY 4: OD-11 IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure)
DY 5: OD-11 IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure)

Related Category 1 and Category 2 Unique RHP Project Identifiers

201320302.2.5 Healthy Families

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Process Milestones: The baseline utilization rates must be established in order to evaluate improvements year to year.

A frequent evaluation cycle to reassess and improve the utilization of preventative services will identify services that are being under-utilized and the reasons and solution for the problem. The cycle must be rapid enough to make adjustments that have the best chance of impacting client behavior.

Outcome: The target population, African-Americans, have significant disparities in birth outcomes. Utilization of preventative services is an essential step in improving those outcomes. One of the success indicators of the program will be the reduction of the disparities in the clients served.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Improvement targets will be established in DY 2 as part of the process establishing the baseline in consultation with the Healthy Families staff.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Healthy Families is an evidence-based program that promotes healthy development and prevention of child maltreatment. A combination of home visiting, parenting education, and connections to health services including prevention services works to achieve the goal of healthy development and child abuse/neglect prevention. Serving a higher percentage of African-American families will address the disparity of over representation of African-Americans in the families and children in the protective services system.

Clients served prenatally should have improved birth outcomes due to earlier prenatal care and improved nutrition. Although a small sample, it is expected that expectant parents in the program earlier in pregnancy will have better outcomes than clients with a shorter service period or the community measures.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

The approach recognizes the importance of preventative health services in contributing to positive birth outcomes, developmental outcomes for the infant, and support of new parents.

Rationale/Justification for Valuation

Pre and postnatal interventions can prevent or ameliorate a number of complications that can impact the child and family for years and increase costs of health care including the cost of remediation of developmental delays. However, the interventions cannot be effective if not used or if used sporadically. Analysis of utilization rates for preventative services is a method to measure both client behavior and program effectiveness. Some examples of cost savings/offsets are:

- Medicaid enrolled children with up-to-date well child checks through 2 years of age are 48% less likely to experience avoidable hospitalization
- Parental injury prevention counseling saves $2,800 per quality adjusted life year
- Vision and hearing screenings are cost-effective preventative services. "Eye disorders are the most common reason that children become handicapped in the United States"

http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_cost-offset.pdf

[Unique Category 3 outcome measure identifier(s), **201320302.3.6**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **IT-11.3**	*[Outcome Measure (Improvement Target) Title]* **OD-11 IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure)**	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			***TPI* 201320302**
Related Category 1 or 2 Projects:	**201320302.2.5** 2.7 Implement Evidence-based Disease Prevention Programs, 2.7.6 Other		
Starting Point/Baseline:	TBD in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 P-4 Plan Do Study Act Cycle • Plan process to collect and analyze utilization rates Data Source: Healthy Families planning, activity, evaluation data and documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,652 **Process Milestone 2** P-2 Establish Baseline Rates • Establish baseline utilization rates Data Source: Healthy Families and CPS caseworker reports Process Milestone 2 Estimated Incentive Payment: $2,652	**Process Milestone 3** P-4 Plan Do Study Act Cycle • Review utilization rates • Identify under-utilized services • Analyze under-utilization and plan response • Implement changes Data Source: Healthy Families planning, activity, evaluation data and documentation, client records and reports Process Milestone 3 Estimated Incentive Payment: $15,910	**Process Milestone 4** P-4 Plan Do Study Act Cycle • Review utilization rates • Identify under-utilized services • Analyze under-utilization and plan response • Implement changes Data Source: Healthy Families planning, activity, evaluation data and documentation, client records and reports Process Milestone 4 Estimated Incentive Payment: $13,258 **Outcome Improvement Target 1** IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. Improvement targets: • Improve immunization rate by 50% over entry rate.	**Outcome Improvement Target 2** IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. Improvement targets: • Improve immunization rate by 10% over DY4 rate. • Improve medical home rate by 10% over DY4 rate. Data Source: Healthy Families reports, client files Outcome Improvement Target 2 Estimated Incentive Payment: $35,355

[Unique Category 3 outcome measure identifier(s), **201320302.3.6**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **IT-11.3**	*[Outcome Measure (Improvement Target) Title]* **OD-11 IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure)**	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			***TPI* 201320302**
Related Category 1 or 2 Projects:	**201320302.2.5** 2.7 Implement Evidence-based Disease Prevention Programs, 2.7.6 Other		
Starting Point/Baseline:	TBD in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
		• Improve medical home rate by 50% over entry rate. Data Source: Healthy Families reports, client files Outcome Improvement Target 1 Estimated Incentive Payment: $13,258	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $5,304	Year 3 Estimated Outcome Amount: $15,910	Year 4 Estimated Outcome Amount: $26,516	Year 5 Estimated Outcome Amount: $35,355
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $83,085			

Title of Outcome Measure (Improvement Target):
IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. *(Non-standalone measure)*

Unique RHP Outcome Identification Number: **201320302.3.7 Pass 2**

Performing Provider Name: **CITY OF AUSTIN HEALTH AND HUMAN SERVICES (HHSD)**

Performing Provider TPI: **201320302**

Outcome Measure Description

Overall Outcome Measure Description
IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. *(Non-standalone measure)*
The outcomes will be tracked for program clients.

Process Milestones for Each Year
DY 2: P-2 Establish Baseline Rates and P-4 Plan Do Study Act Cycle
DY 3: P-4 Plan Do Study Act Cycle
DY 4: P-4 Plan Do Study Act Cycle
DY 5:

Outcome Improvement Targets for Each Year:
DY 2:
DY 3:
DY 4: OD-11 **IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. *(Non-standalone measure)***
DY 5: OD-11 **IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. *(Non-standalone measure)***

Related Category 1 and Category 2 Unique RHP Project Identifiers
201320302.2.5 Healthy Families

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Process Milestones: A frequent evaluation cycle to assess client satisfaction assessments will provide information for program adjustments and improvements to impact client satisfaction and quality of life scores.

Establishing baseline rates is an important step in measures client improvement and program effectiveness.

Outcome: Program satisfaction is especially critical for all clients but specifically the target population of African-American clients since it impacts retention and participation in the program. Preventative measures such as increasing health literacy and making healthy practices routine take time to establish.

Word-of-mouth may also be a critical outreach and recruitment method, and its value will depend on positive client reports.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Improvement targets will be established in DY 2 as part of the process establishing the baseline in consultation with the Healthy Families staff.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Healthy Families is an evidence-based program that promotes healthy development and prevention of child maltreatment. A combination of home visiting, parenting education, and connections to health services including prevention services works to achieve the goal of healthy development and child abuse/neglect prevention. Serving a higher percentage of African-American families will address the disparity of over representation of African-Americans in the families and children in the protective services system.

Clients served prenatally should have improved birth outcomes due to earlier prenatal care and improved nutrition. Although a small sample, it is expected that expectant parents in the program earlier in pregnancy will have better outcomes than clients with a shorter service period or the community measures.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

The approach recognizes the importance of early childhood development and the critical work of prevention programs in preventing insults to human development. The community also recognizes the disparity of African-Americans involvement with the child protection system and in birth outcomes.

Rationale/Justification for Valuation

Client retention and participation will directly impact program participation rates, and clients' satisfaction with the program and changes in quality of life can provide evidence of program quality. Active participation can produce positive results for birth outcomes and child development. Pre and postnatal interventions can prevent or ameliorate a number of complications that can impact the child and family for years and increase costs of health care including the cost of remediation of developmental delays. Other community costs include educational consequences. Some examples of cost savings/offsets are:

- Medicaid enrolled children with up-to-date well child checks through 2 years of age are 48% less likely to experience avoidable hospitalization
- Parental injury prevention counseling saves $2,800 per quality adjusted life year
- Vision and hearing screenings are cost-effective preventative services. "Eye disorders are the most common reason that children become handicapped in the United States"

http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_cost-offset.pdf

[Unique Category 3 outcome measure identifier(s), **201320302.3.7**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **IT-11.4**	*[Outcome Measure (Improvement Target) Title]* **IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity.** ***(Non-standalone measure)***	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			***TPI*** **201320302**
Related Category 1 or 2 Projects:	**201320302.2.5** 2.7 Implement Evidence-based Disease Prevention Programs, 2.7.6 Other		
Starting Point/Baseline:	TBD in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 P-4 Plan Do Study Act Cycle • Design satisfaction/quality of life assessment processes and tools • Train staff in use of tools Data Source: Healthy Families planning, activity, evaluation data and documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,652 **Process Milestone 2** P-2 Establish Baseline Rates Data Source: Healthy Families and CPS caseworker reports Process Milestone 2 Estimated	**Process Milestone 3** P-4 Plan Do Study Act Cycle • Conduct pre-tests at intake • Analyze pre-test results for possible actions • Administer satisfaction/quality of life assessments at determined intervals • Analyze results for action including program changes Data Source: Healthy Families planning, activity, evaluation data and documentation Process Milestone 3 Estimated Incentive Payment: $15,910	**Process Milestone 4** P-4 Plan Do Study Act Cycle • Conduct pre-tests at intake • Analyze pre-test results for possible actions • Administer satisfaction/quality of life assessments at determined intervals • Analyze results for action including program changes Data Source: Healthy Families planning, activity, evaluation data and documentation Process Milestone 4 Estimated Incentive Payment: $13,258 **Outcome Improvement Target 1** - IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. Improvement Target: Patient (family)	**Outcome Improvement Target 2** - IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. Improvement Target: Patient (family) satisfaction rates average at least 90% Data Source: Healthy Families and CPS caseworker reports Outcome Improvement Target 2 Estimated Incentive Payment: $35,355

[Unique Category 3 outcome measure identifier(s), **201320302.3.7**	*[Outcome Measure (Improvement Target) Reference number from RHP Planning Protocol, e.g. 3.IT-X.X]* **IT-11.4**	*[Outcome Measure (Improvement Target) Title]* **IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity. *(Non-standalone measure)***	
CITY OF AUSTIN HEALTH AND HUMAN SERVICES DEPARTMENT			***TPI* 201320302**
Related Category 1 or 2 Projects:	**201320302.2.5** 2.7 Implement Evidence-based Disease Prevention Programs, 2.7.6 Other		
Starting Point/Baseline:	TBD in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Incentive Payment: $2,652		satisfaction rates average at least 85% Data Source: Healthy Families and CPS caseworker reports Outcome Improvement Target 1 Estimated Incentive Payment: $13,258	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $5,304	Year 3 Estimated Outcome Amount: $15,910	Year 4 Estimated Outcome Amount: $26,516	Year 5 Estimated Outcome Amount: $35,355
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**			$83,085

Title of Outcome Measure (Improvement Target): **IT-11.1: Improvement in Clinical Indicator in identified disparity group.**

Unique RHP Outcome Identification Number: **201320302.3.8**

Performing Provider Name: **City of Austin Health and Human Services**

Performing Provider TPI: **201320302**

Outcome Measure Description

Overall Outcome Measure Description

This outcome measure will indicate how successful we are in increasing the proportion of adult high-risk adult who receive appropriate vaccinations. It measures the number of clients immunized (numerator) against the total number of clients served in the STD/HIV clinic (denominator).

Process Milestones for Each Year

Outcome Improvement Targets for Each Year:

DY 2: Increase utilization of appointments to target populations by 2%
DY 3: Increase utilization of appointments to target populations by 2%
DY 4: Increase utilization of appointments to target populations by 2%
DY 5: Increase utilization of appointments to target populations by 2%

Related Category 1 and Category 2 Unique RHP Project Identifiers

Category 2/Intervention 7: Implement Evidence-based Disease Prevention Programs

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

This project seeks to target vaccinations to vulnerable populations at higher risk for vaccine preventable diseases. Clients seeking treatment for sexually transmitted diseases and/or HIV screening are at higher risk for infection of Hep A, Hep B, and HPV in particular. We are also seeking to target homeless populations, Men who have sex with Men (MSM), LGBT youth, and substance abuse populations; as these groups are also at higher risk for certain vaccine preventable diseases. There is much research supporting specific vaccinations for each group given their unique vulnerabilities.

As for Category three, we believe the best outcome measure for this project is to gauge our clinic utilization rates given the endemic challenges we face in providing clinical services to high-risk / complex need populations.

In a typical immunization clinic a valid and reliable quality improvement indicator is an "up-to-date" percentage (i.e. immunization rate). This works well in a clinic with a set number of clients seen regularly (denominator) and can measure the number of clients that are actually up to date (numerator). However, with the populations we are proposing to target (homeless, MSM, HIV infected, intravenous drug users, etc.) we won't be able to track that outcome indicator.

The best outcome indicator(s) given these challenges endemic to high-risk/complex need clients is to provide a clinic utilization rate(s); especially since we are targeting high-risk/complex-need clients. We will measure the number of clients we immunized (numerator) against the number total clients served in the STD/HIV clinic (denominator).The city's STD/HIV clinic is the starting point for program expansion and where many of our at risk adults come to seek services.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Expanding access to immunization services will increase both the number and the proportion of at-risk adults who are appropriately vaccinated.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

There is a disparity of access to vaccination services and achieving positive health outcomes for the identified population groups. Our objective is to increase access and utilization of these services to decrease morbidity and mortality for vaccine preventable diseases.

Rationale/Justification for Valuation

This integrated approach provides an immediate point of entry to preventative care, lessoning disparity to populations that might not otherwise seek vaccine preventable treatment.

201320302.3.8	IT-11.1	11.3 Improvement in Clinical Indicator in identified disparity group	
City of Austin Health & Human Services Department			201320302
Related Category 1 or 2 Projects:	201320302.2.6		
Starting Point/Baseline:	TBD in DY2		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates for vaccination rate at STD/HIV clinic Data Source: TWICES (electronic Client Database) Process Milestone 1 Estimated Incentive Payment*:* $104,383	**Outcome Improvement Target 1** [IT-11.1]: Improvement Target: Improve vaccination rate by 2% over baseline. Data Source: TWICES (electronic Client Database) Outcome Improvement Target 1 Estimated Incentive Payment*:* $212,941	**Outcome Improvement Target 2** [IT-11.1]: Improvement Target: Improve vaccination rate by 2% over prior year. Data Source: TWICES (electronic Client Database) Outcome Improvement Target 2 Estimated Incentive Payment*:* $217,200	**Outcome Improvement Target 3** [IT-11.1]: Improvement Target: Improve vaccination rate by 2% over prior year. Data Source: TWICES (electronic Client Database) Outcome Improvement Target 3 Estimated Incentive Payment*:* $443,088
Year 2 Estimated Outcome Amount: $104,383	Year 3 Estimated Outcome Amount: $212,941	Year 4 Estimated Outcome Amount: $217,200	Year 5 Estimated Outcome Amount: $443,088
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $977,612			

Community Care Collaborative
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): **IT-1.4 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) - diuretic**

Unique RHP Outcome Identification Number: 307459301**.3.24**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

Percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Numerator: Members from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Denominator: Members 18 years of age and older as of December 31 of the measurement year on persistent diuretics -- defined as members who received at least 180 treatment days of ambulatory medication during the measurement year

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to determine annual diuretic monitoring rates for the CCC's contracted providers. This planning process will also establish targets for improvement in monitoring rates.
DY 3:
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3: Improve annual monitoring for patients on diuretics by TBD.
DY 4: Improve annual monitoring for patients on diuretics by TBD.
DY 5: Improve annual monitoring for patients on diuretics by TBD.

Related Category 1 Unique RHP Project Identifiers

307459301.1.1: The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Annual monitoring of patients on persistent medication is a critical component of good patient care. This Improvement Target, which aims to *increase the percentage of CCC patients 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year*, represents a commitment to quality care for chronic diseases that the CCC will achieve through implementing and enhancing new Disease Management Registry functionalities. Many patients in the CCC population will be eligible for treatment with diuretics.

In DY 2, the CCC will develop the baseline annual monitoring rates for patients on diuretics. In DYs 3, 4, and 5, the CCC will monitor improvements in the outcome improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The Improvement targets will be determined in DY2.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project will establish CCC-wide Disease Management Registry functionalities. The enhanced disease management capabilities will allow care teams, and patients themselves, to better manage chronic conditions. This management includes annual monitoring of patients on persistent medications to ensure that side-effects are being controlled and dosage is at appropriate levels.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.24	*3.IT-1.4*	*Annual monitoring for patients on diuretics*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.1: The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities*		
Starting Point/Baseline:	*TBD in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process Data Source: Documentation of a planning process to determine the rate of annual monitoring and appropriate targets for improvement. Process Milestone 1 Estimated Incentive Payment*:* $343,373	**Outcome Improvement Target 1** [IT-1.4]: Increase rate of annual monitoring for patients on diuretics. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $483,266	**Outcome Improvement Target 2** [IT-1.4]: Increase rate of annual monitoring for patients on diuretics. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $635,876	**Outcome Improvement Target 3** [IT-1.4]: Increase rate of annual monitoring for patients on diuretics. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,068,272
Year 2 Estimated Outcome Amount:: $343,373	Year 3 Estimated Outcome Amount: $483,266	Year 4 Estimated Outcome Amount: $635,876	Year 5 Estimated Outcome Amount: $1,068,272
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,530,787			

Title of Outcome Measure (Improvement Target): **IT-1.12 Diabetes care: Retinal eye exam (NQF 0055)**
Unique RHP Outcome Identification Number: 307459301**.3.25**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or
- A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2).

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to determine the annual eye exam rates for diabetics among the CCC's contracted providers. This planning process will also establish targets for improvement in monitoring rates.
DY 3:
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3: Improve rates of retinal eye screening for patients by TBD.
DY 4: Improve rates of retinal eye screening for patients by TBD.
DY 5: Improve rates of retinal eye screening for patients by TBD.

Related Category 1 Unique RHP Project Identifiers

307459301.1.1 The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Diabetic retinopathy is a leading cause of blindness among Americans, and occurs in almost half of Americans diagnosed with diabetes (NIH National Eye Institute). Annual monitoring of patients' retinal health can identify incipient retinopathy and enable care teams and patients to address and slow the progression of this complication. This Improvement Target, which aims to *increase the percentage of CCC patients 18 to 75 years of age who have type 1 or 2 diabetes and had an eye screening for diabetic retinal diseases in the measurement year*, represents a commitment to quality care for diabetes that the CCC will achieve through implementing and enhancing new Disease Management Registry functionalities.

In DY 2, the CCC will develop the baseline annual retinal exam rates for diabetic patients. In DYs 3, 4, and 5, the CCC will monitor improvements in the screening rate.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The Improvement targets will be determined in DY2.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project will establish CCC-wide Disease Management Registry functionalities. The enhanced disease management capabilities will allow care teams, and patients themselves, to better manage chronic conditions. This management includes ensuring that diabetics – a large number of the CCC's population – are receiving the appropriate annual care.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.25	*3.IT-1.12*	*Diabetes care: Retinal eye exam*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.1: The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities*		
Starting Point/Baseline:	*TBD in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process Data Source: Documentation of a planning process to determine the rate of annual monitoring and appropriate targets for improvement. Process Milestone 1 Estimated Incentive Payment*:* $343,373	**Outcome Improvement Target 1** [IT-1.12]: Increase rate of annual retinal eye exams for patients with Type 1 and Type 2 diabetes. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $483,266	**Outcome Improvement Target 2** [IT-1.12]: Increase rate of annual retinal eye exams for patients with Type 1 and Type 2 diabetes. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $635,876	**Outcome Improvement Target 3** [IT-1.12]: Increase rate of annual retinal eye exams for patients with Type 1 and Type 2 diabetes. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,068,272
Year 2 Estimated Outcome Amount:: $343,373	Year 3 Estimated Outcome Amount: $483,266	Year 4 Estimated Outcome Amount: $293,033	Year 5 Estimated Outcome Amount: $1,068,272
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,530,787			

Title of Outcome Measure (Improvement Target): **IT-1.14 Diabetes care: Microalbumin/Nephropathy (NQF 0062)**
Unique RHP Outcome Identification Number: 307459301**.3.26**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description
A test to

Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.

Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 or type 2).

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to determine the annual diabetic nephropathy screening rates among the CCC's contracted providers. This planning process will also establish targets for improvement in this screening rate.
DY 3:
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3: Improve rates of annual screenings for diabetic nephropathy by TBD.
DY 4: Improve rates of annual screenings for diabetic nephropathy by TBD.
DY 5: Improve rates of annual screenings for diabetic nephropathy by TBD.

Related Category 1 Unique RHP Project Identifiers

307459301.1.1 The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Diabetes is the most common cause of End Stage Renal Disease in the United States, and approximately 40% of patients with Type 1 diabetes will develop ESRD. This number is higher among certain racial and ethnic groups (America Diabetes Association). Annual monitoring of patients' renal health can identify incipient nephropathy and enable care teams and patients to address and slow the progression of this complication. This Improvement Target, which aims to *increase the percentage of CCC patients 18 to 75 years of age who have type 1 or 2 diabetes and had a screening procedure for nephropathy in the measurement year*, represents a commitment to quality care for diabetes that the CCC will achieve through implementing and enhancing new Disease Management Registry functionalities.

In DY 2, the CCC will develop the baseline annual nephropathy screening rates for diabetic patients. In DYs 3, 4, and 5, the CCC will monitor improvements in the outcome improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The Improvement targets will be determined in DY2.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project will establish CCC-wide Disease Management Registry functionalities. The enhanced disease management capabilities will allow care teams, and patients themselves, to better manage chronic conditions. This management includes ensuring that diabetics – a large number of the CCC's population – are receiving the appropriate annual care.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.26	*3.IT-1.14*	*Diabetes care: Nephropathy Screening*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.1: The Community Care Collaborative's Implementation and Enhancement of Chronic Disease Management Registry Functionalities*		
Starting Point/Baseline:	*TBD in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process Data Source: Documentation of a planning process to determine the rate of annual nephropathy screening and appropriate targets for improvement. Process Milestone 1 Estimated Incentive Payment*:* $343,373	**Outcome Improvement Target 1** [IT-1.12]: Increase rate of annual nephropathy screening for patients with Type 1 and Type 2 diabetes. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $483,266	**Outcome Improvement Target 2** [IT-1.12]: Increase rate of annual nephropathy screening for patients with Type 1 and Type 2 diabetes. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $635,876	**Outcome Improvement Target 3** [IT-1.12]: Increase rate of annual nephropathy screening for patients with Type 1 and Type 2 diabetes. Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,068,272
Year 2 Estimated Outcome Amount:: $343,373	Year 3 Estimated Outcome Amount: $483,266	Year 4 Estimated Outcome Amount: $635,876	Year 5 Estimated Outcome Amount: $1,068,272
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,530,787			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 307459301.3.2

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description: IT-9.2: ED Appropriate Utilization

The outcome measure for this project will focus on ED utilization for Ambulatory Care Sensitive Conditions identified by the Agency for Healthcare Research and Quality.

Process Milestones for Each Year

DY 2: P-3: Develop and test data systems to identify ED utilization of the target population for Ambulatory Care Sensitive Conditions
DY 3: P-2: Establish baseline rates for ED utilization of the target population for Ambulatory Care Sensitive Conditions
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: TBD % reduction in ED visits for Ambulatory Care Sensitive Conditions in DY4.
DY 5: TBD % reduction in ED visits for Ambulatory Care Sensitive Conditions in DY5.

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.1.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets.
DY 2 and DY3 will evaluate data systems by building on existing EHR and HIE capabilities to measure ED utilization and establish a baseline for the target population.

The related project aims to reduce unnecessary ED utilization through expanded access to primary care. As a result, the outcome measure for this project will focus on ED utilization for Ambulatory Care Sensitive Conditions identified by the Agency for Healthcare Research and Quality. Through extended clinic hours, staffing, and service locations, the Community Care Collaborative (CCC) anticipates a reduction in ED utilization for Ambulatory Care Sensitive Conditions in DY4 and DY5

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3. Baseline ED utilization for Ambulatory Care Sensitive Conditions will be established during DY3. Using this baseline, outcome improvement targets will be refined for DY4 and DY5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure. Low-income patients have limited options for after-hours primary care, and uninsured and underinsured patients in Travis County frequently utilize local EDs for non-emergent medical issues.

By increasing access to primary care, including after-hours availability, the related Category 1 project aims to reduce unnecessary ED utilization by shifting care to the most appropriate and cost-effective setting. In addition, improved chronic care management will reduce the likelihood that these conditions develop into acute episodes requiring emergency care.

Outcome Measure Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative considered the overall value of the related Category 1 project and the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.2	*IT-9.2*	*ED Appropriate Utilization for Ambulatory Care Sensitive Conditions*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 projects :	*307459301.1.2 - Expanded Primary Care Hours at Community-Based Outpatient Settings*		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems to capture ED utilization of target population for Ambulatory Care Sensitive Conditions. Data Source: EHR/HIE, Project Plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 801,531	**Process Milestone 2** [P-2]: Establish baseline rates for ED utilization of target population for Ambulatory Care Sensitive Conditions. Data Source: EHR/HIE Process Milestone 2 Estimated Incentive Payment: $ 1,128,081	**Outcome Improvement Target 1** [IT-9.2]: Improvement Target: TBD % reduction in ED visits for Ambulatory Care Sensitive Conditions in DY4. Data Source: EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,484,317	**Outcome Improvement Target 2** [IT-9.2]: Improvement Target: TBD % reduction in ED visits for Ambulatory Care Sensitive Conditions in DY5. Data Source: EHR/HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $2,493,652
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 801,531	Year 3 Estimated Outcome Amount: $ 1,128,081	Year 4 Estimated Outcome Amount: $ 1,484,317	Year 5 Estimated Outcome Amount: $ 2,493,652
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 5,907,581			

Title of Outcome Measure (Improvement Target): **IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)**
Unique RHP Outcome Identification Number: **307459301.3.27**
Performing Provider Name: **Community Care Collaborative**
Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

Adequate control of blood pressure among mobile health clinic patients who have hypertension.

Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.
Denominator: CCC mobile clinic patients 18-85 years of age as of December 31 of the measurement year with a diagnosis of hypertension.

Process Milestones for Each Year

DY 2: P-1: Project Planning – develop clinic workflow protocols specific for mobile health clinics for ensuring appropriate monitoring and control of high blood pressure among mobile clinic patients.
DY 3: P-3: Develop and test data systems
P-2: Establish baseline rates of controlled blood pressure among the mobile clinic population
P-7: Establish improvement target for controlled blood pressure.
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: IT1.7 Increase the number of CCC Mobile Health Clinic patients whose most recent blood pressure is adequately controlled (less than 140/90 mm Hg) by TBD %
DY 5: IT1.7 Increase the number of CCC Mobile Health Clinic patients whose most recent blood pressure is adequately controlled (less than 140/90 mm Hg) by TBD %

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.3 Expand Primary Care Capacity via Mobile Health Clinics

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

In DY 2, the project will complete a planning process to develop work flow protocols for mobile health patients that have high blood pressure. In DY 3, as the program begins seeing patients, the project will establish a baseline blood pressure rates for the population and determine an appropriate improvement target for the demonstration period. Additionally, the program will ensure that the mobile health clinical

records are incorporated into the CCC HIE. Finally, the CCC expects to see an increase in the number of Mobile Health Clinic patients whose blood pressure is adequately controlled as a result of improved access to comprehensive primary care and chronic disease management.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project will expand access to primary care to geographically underserved areas of Travis County. As a result, patients with chronic diseases in these areas will have access to a medical home where their chronic conditions can be managed. High blood pressure is a common concern among the CCC target population, so this condition will be carefully monitored for improvements among the CCC mobile clinic population.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.1.27	*3.IT-1.7*	*Controlling High Blood Pressure*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.3 Expand Primary Care Capacity via Mobile Clinics*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning: Engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of clinic workflow protocols for monitoring and controlling high blood pressure among mobile health clinic patients. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $76,269	**Process Milestone 2 [P-4] Develop and test data systems** Data Source: Evidence that mobile health clinic high blood pressure patient data is incorporated into the CCC's HIE. Process Milestone 2 Estimated Incentive Payment: $35,780 **Process Milestone 3 [P-4] Establish baseline rate for controlling high blood pressure.** Data Source: **CCC HIE** Process Milestone 3 Estimated Incentive Payment: $35,781	**Outcome Improvement Target 1** [IT-1.7]: Increase the number of CCC Mobile Health Clinic patients whose most recent blood pressure is adequately controlled (less than 140/90 mm Hg) by TBD % Improvement Target: TBD Data Source: CCC HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $237,282	**Outcome Improvement Target 2** [IT-1.7]: Increase the number of CCC Mobile Health Clinic patients whose most recent blood pressure is adequately controlled (less than 140/90 mm Hg) by TBD % Improvement Target: TBD Data Source: CCC HIE Outcome Improvement Target 3 Estimated Incentive Payment*:* $562,132

307459301.1.27	*3.IT-1.7*	*Controlling High Blood Pressure*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.3 Expand Primary Care Capacity via Mobile Clinics*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Process Milestone 4 [P-4] Establish improvement target for improvements in controlling high blood pressure. Data Source: **CCC HIE** Process Milestone 4 Estimated Incentive Payment: $35,781		
Year 2 Estimated Outcome Amount: $76,269	Year 3 Estimated Outcome Amount: $107,342	Year 4 Estimated Outcome Amount: $237,282	Year 5 Estimated Outcome Amount: $562,132
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $562,132			

Title of Outcome Measure (Improvement Target): **IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011 #134)**

Unique RHP Outcome Identification Number: **307459301.3.28**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

Numerator: CCC Mobile Health Clinic patients aged 18 and older who were screened for depression and have a follow-up plan documented.
Denominator: CCC Mobile Health Clinic patients aged 18 and older.

Process Milestones for Each Year

DY 2: P-1: Project Planning – develop clinic work flow protocols specific to mobile health clinics for screening and treatment plans for depression.
DY 3: P-3: Develop and test data systems
P-2: Establish baseline rates
P-7: Establish improvement target
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: Increase the number of CCC Mobile Health Clinic patients who have been screened for depression and have a documented follow-up plan by TBD%.
DY 5: Increase the number of CCC Mobile Health Clinic patients who have been screened for depression and have a documented follow-up plan by TBD%.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.3 Expand Primary Care Capacity via Mobile Health Clinics

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

In DY 2, the project will complete a planning process to develop clinic workflow protocols to screen and treat mobile health clinic patients for depression. In DY 3, as the program begins seeing patients, the project will establish a baseline depression screening and treatment rates for the population and determine an appropriate improvement target for the demonstration period. Additionally, the program will ensure that the mobile health clinical records are incorporated into the CCC HIE. Finally, the CCC expects to see an increase in the number of Mobile Health Clinic patients who are screened for depression and have a documented follow up plan as a result of improved access to comprehensive primary care and chronic disease management.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project will expand access to primary care to geographically underserved areas of Travis County. As a result, patients with chronic diseases in these areas will have access to a medical home where their chronic conditions can be managed. Depression is a common concern among the CCC target population, so this condition will be carefully monitored for improvements among the CCC mobile clinic population.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.28	*3-IT.1.8*	*Screening and Treatment Plan for Clinical Depression*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.3 Expand Primary Care Capacity via Mobile Health Clinics*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning: Engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documented set of clinic workflow protocols to ensure screening for depression and treatment plan development. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $76,269	**Process Milestone 2 [P-4] Develop and test data systems** Data Source: Evidence that mobile health clinic depression patient data is incorporated into the CCC's HIE. Process Milestone 2 Estimated Incentive Payment: $35,780 **Process Milestone 3 [P-4] Establish baseline rate.** Data Source: **CCC HIE** Process Milestone 3 Estimated Incentive Payment: $35,781	**Outcome Improvement Target 1** [IT-1.8]: Increase the number of CCC Mobile Health Clinic patients who have been screened for depression and have a documented follow-up plan by TBD%. Improvement Target: TBD Data Source: CCC HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $141,240	**Outcome Improvement Target 2** [IT-1.8]: Increase the number of CCC Mobile Health Clinic patients who have been screened for depression and have a documented follow-up plan by TBD%. Improvement Target: TBD Data Source: CCC HIE Outcome Improvement Target 3 Estimated Incentive Payment*:* $237,282

307459301.3.28	*3-IT.1.8*	*Screening and Treatment Plan for Clinical Depression*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.3 Expand Primary Care Capacity via Mobile Health Clinics*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Process Milestone 4 [P-4] **Establish improvement target.** Data Source: **CCC HIE** Process Milestone 4 Estimated Incentive Payment: $35,781		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $76,269	Year 3 Estimated Outcome Amount: $107,342	Year 4 Estimated Outcome Amount: $141,240	Year 5 Estimated Outcome Amount: $237,282
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $562,133			

Title of Outcome Measure (Improvement Target): **IT 1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059**

Unique RHP Outcome Identification Number: **307459301.3.29**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

Numerator: Percentage of CCC mobile health clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0%.
Denominator: CCC mobile health clinic patients 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

Process Milestones for Each Year

DY 2: P-1: Project Planning – develop clinic workflow protocols to track and monitor care for patients with diabetes.
DY 3: P-3: Develop and test data systems
P-2: Establish baseline rates
P-7: Establish improvement target
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: Decrease the number of CCC Mobile Health Clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0% by TBD %.
DY 5: Decrease the number of CCC Mobile Health Clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0% by TBD %.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.3 Expand Primary Care Capacity via Mobile Health Clinics

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

In DY 2, the project will complete a planning process to develop a care management plan for mobile health patients that have diabetes. In DY 3, as the program begins seeing patients, the project will establish a baseline HbA1c rates for the population and determine an appropriate improvement target for

the demonstration period. Additionally, the program will ensure that the mobile health clinical records are incorporated into the CCC HIE. Finally, the CCC expects to see a decrease in the number of Mobile Health Clinic patients whose diabetes is inadequately controlled as a result of improved access to comprehensive primary care and chronic disease management.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project will expand access to primary care to geographically underserved areas of Travis County. As a result, patients with chronic diseases in these areas will have access to a medical home where their chronic conditions can be managed. Diabetes is a common concern among the CCC target population, so this condition will be carefully monitored for improvements among the CCC mobile clinic population.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.29	*3.IT.1.10*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.3 Expand Primary Care Capacity via Mobile Health Clinics*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning: Engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of clinic workflow protocols for monitoring and controlling diabetes among mobile health clinic patients. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $	**Process Milestone 2 [P-4] Develop and test data systems** Data Source: Evidence that mobile health clinic diabetes patient data is incorporated into the CCC's HIE. Process Milestone 2 Estimated Incentive Payment: $35,780 **Process Milestone 3 [P-4] Establish baseline rate.** Data Source: **CCC HIE** Process Milestone 3 Estimated Incentive Payment: $35,781	**Outcome Improvement Target 2** [IT-1.10]: Decrease the number of CCC Mobile Health Clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0% by TBD %. Improvement Target: TBD Data Source: CCC HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $	**Outcome Improvement Target 3** [IT-1.10]: Decrease the number of CCC Mobile Health Clinic patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control >9.0% by TBD %. Improvement Target: TBD Data Source: CCC HIE Outcome Improvement Target 3 Estimated Incentive Payment*:* $

307459301.3.29	*3.IT.1.10*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.3 Expand Primary Care Capacity via Mobile Health Clinics*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Process Milestone 4 [P-4] **Establish improvement target.** Data Source: **CCC HIE** Process Milestone 4 Estimated Incentive Payment: $35,781		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $76,270	Year 3 Estimated Outcome Amount: $107,342	Year 4 Estimated Outcome Amount: $141,240	Year 5 Estimated Outcome Amount: $562,135
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $562,135			

Title of Outcome Measure (Improvement Target): IT-7.8: Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

Unique RHP outcome identification number(s): 307459301.3.4

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description: IT-7.8: Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

- Numerator: Number of chronic disease patients who access dental services as the result of a referral
- Denominator: Total number of referrals for dental services for chronic disease patients by medical providers

Process Milestones for Each Year:

DY 2: P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3: P-3: Develop and test data systems to track referrals for dental services from medical providers
P-2: Establish baseline rates
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: TBD % in percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider
DY 5: TBD % in percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.1.4

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets:

Providing dental care for patients with chronic conditions is integral to the CCC's emphasis on whole health, prevention, and wellness. Patients are more likely to seek dental services when given a formal

referral. The CCC will inform medical providers throughout its network of new dental appointment availability and will coordinate referrals from medical providers for patients with chronic medical conditions.

Tracking referrals between safety net providers will require a lot of work. DY2 and DY3 will be devoted to conceptualizing, developing and testing these data systems to track provider referrals by building on existing EHR and HIE capabilities. During DY3, baseline rates will be established for the percentage of patients with chronic disease conditions who access dental services following referral by their medical provider.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Baseline rates for the percentage of patients with chronic disease conditions who access dental services following referral by their medical provider will be established during DY3. Using this baseline, outcome improvement targets will be refined for DY4 and DY5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The CCC will coordinate with medical providers throughout its network to develop clinical processes and adapt existing data systems in order to create and track referrals for dental services.

Through expanded access to care, the CCC will increase the number of patients with multiple chronic medical conditions receiving dental care. The CCC will coordinate referrals from medical providers and provide patient navigation to ensure that patients with chronic conditions receive priority for dental appointments.

Outcome Measure Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative considered the overall value of the related Category 1 project and the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.4	*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*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 projects :	*307459301.1.4 – Expansion of Dental Services*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Plans detailing Referral Tracking Challenges, Solutions, and Proposed Tracking System Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 680,209	**Process Milestone 2** [P-3]: Develop and test data systems to track referrals for dental services from medical providers Data Source: EHR/HIE; Project Plans Process Milestone 2 Estimated Incentive Payment: $ 478,666 **Process Milestone 3** [P-2]: Establish baseline rates for percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider Data Source: EHR/HIE Process Milestone 3 Estimated Incentive Payment: $ 478,666	**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: TBD % increase in percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider Data Source: EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,259,647	**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: TBD % increase in percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider Data Source: EHR/HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $2,116,207
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 680,209	Year 3 Estimated Outcome Amount: $ 957,332	Year 4 Estimated Outcome Amount: $ 1,259,647	Year 5 Estimated Outcome Amount: $ 2,116,207
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$ 5,013,395**			

Title of Outcome Measure (Improvement Target): **Quality of Life**

Unique RHP Outcome Identification Number: **307459301.3.5**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

10.1 – Quality of Life. The project aims to improve the quality of life of the target population by expanding the capacity and broadening the spectrum of musculoskeletal services available so that chronic pain and other conditions can be addressed in a timely and successful way, thus improving patient quality of life.

Process Milestones for Each Year

DY 2: P-1 Project Planning. Determine the appropriate Quality of Life measure to use for the project.

DY 3: P-3 Develop and test data systems. Ensure quality of life data collection is incorporated into CCC EHR.

P-2 Establish a baseline rate.
P-7 Establish an improvement target.

DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: Improve patient quality of life by TBD% over baseline.
DY 5: Improve patient quality of life by TBD% over baseline.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.5 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Currently, safety net providers are not measuring patient quality of life in a consistent way. Initially, the CCC will work with existing safety net providers to decide which quality of life measure is most appropriate to assessing quality of life improvements associated with musculoskeletal services (P-1). Once the measure is selected, the provider will conduct a baseline assessment in DY 3 (P-2). Once the baseline

has been assessed, the provider can then assess an appropriate outcome improvement target to meet during DY 4 and 5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Patients in the target population suffer from a variety of musculoskeletal conditions that hinder movement but may or may not be alleviated by surgical services. This project will allow the CCC to provide musculoskeletal services in the community setting to address non-surgical patient needs. By addressing issues more quickly and effectively, patients will be able to return to normal life functioning more quickly, improving quality of life.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.5	*3.IT-10.1*	*Quality of Life*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	307459301.1.5 – Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions		
Starting Point/Baseline:	*To be determined in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Determine the appropriate Quality of Life measure to use for the project. Data Source: Documentation of measure determination. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $226,130	**Process Milestone 2** [P-3]: Develop and test data systems – Ensure quality of life data collection is incorporated into CCC EHR. Data Source: Functional EHR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $106,085 **Process Milestone 3 [P-2]:** Establish a baseline rate Data Source: Clinical encounter data. Process Milestone 3 Estimated Incentive Payment: $106,086 **Process Milestone 4 [P-7]:** Establish an improvement target	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life Improvement Target: TBD% improvement over baseline. Data Source: Clinical encounter data Outcome Improvement Target 1 Estimated Incentive Payment*:* $418,759	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life Improvement Target: TBD% improvement over baseline. Data Source: Clinical encounter data Outcome Improvement Target 2 Estimated Incentive Payment*:* $703,516

307459301.3.5	*3.IT-10.1*	*Quality of Life*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	307459301.1.5 – Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions		
Starting Point/Baseline:	*To be determined in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Data Source: Clinical encounter data. Process Milestone 4 Estimated Incentive Payment: $106,086		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $226,130	Year 3 Estimated Outcome Amount: $318,257	Year 4 Estimated Outcome Amount: $418,759	Year 5 Estimated Outcome Amount: $703,516
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,666,662			

Title of Outcome Measure (Improvement Target): **IT-1.1 Third Next Available Appointment**

Unique RHP Outcome Identification Number: **307459301.3.30**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

Average length of time in days between the day a patient makes a request for an appointment with an orthopedist and the third available appointment for a new patient, routine exam, or return visit exam. This project will reduce the number of days until the third next available appointment to see an orthopedist.

Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit with an orthopedist in the CCC's network.

Denominator: This measure applies to providers within the CCC.

Process Milestones for Each Year

DY 2: P-1 Project Planning: CCC providers will develop a patient and provider education plan related to use of non-surgical musculoskeletal therapies rather than orthopedic consults when appropriate.

DY 3: P-7 Establish improvement target. CCC providers will determine the target for number of days to decrease third next available appointment time for orthopedists.

DY 4:

DY 5:

Outcome Improvement Targets for Each Year:

DY 2:

DY 3:

DY 4: Decrease the number of days until the third next available orthopedist appointment by TBD%.

DY 5: Decrease the number of days until the third next available orthopedist appointment by TBD%.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.5 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Third next available appointment is the standard measure to understand how quickly a patient can access needed care. The overall goal of this project is to achieve improved access to non-surgical musculoskeletal services. The result of this increased access is expected to achieve parallel increased access to orthopedic surgeons because appointments with orthopedic surgeons that had previously been occupied by patients who did not need surgery can be made available more quickly to those patients that truly do need an orthopedic consultation

In DY 2, the CCC will assess the level of increased access to non-surgical musculoskeletal care, assess the true need for orthopedic consultations among the target population, and determine a target for reducing time to third next available appointment for orthopedic surgeons.

In DYs 3, 4, and 5, the CCC will monitor improvements in the outcome improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The first non-surgical musculoskeletal providers will be hired in DY 3. As a result, wait times for orthopedic surgeons are expected to decrease slightly in DY 3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project increases the number of community-based musculoskeletal providers offering non-surgical therapies that will be available to the target population. Currently the only functional mobility or pain management providers available to the target population are orthopedic surgeons. Wait times for orthopedic surgeons average more than six months. The CCC expects that many of the patients waiting for orthopedic consultations may be more appropriately served in community-based settings by providers who offer non-surgical therapies for their musculoskeletal conditions. There are currently no non-surgical options for patients with musculoskeletal concerns. As access to non-surgical providers increases, wait times for orthopedic consultations are expected to decrease as appointments are reserved for patients who truly need to see a surgeon.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time, and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.30	*3.IT.1.1*	*Third Next Available Appointment*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.5 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions*		
Starting Point/Baseline:	*241 days*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning Data Source: Documentation of a patient and provider education plan. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $226,130	**Process Milestone 1** [P-7]: Establish improvement target. Data Source: Clinical encounter data. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $318,257	**Outcome Improvement Target 2** [IT-1.1]: Decrease number of days until third next available orthopedic appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 1 Estimated Incentive Payment*:* $418,759	**Outcome Improvement Target 3** [IT-1.1]: Decrease number of days until third next available orthopedic appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 1 Estimated Incentive Payment*:* $703,516
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $226,130	Year 3 Estimated Outcome Amount: $318,257	Year 4 Estimated Outcome Amount: $418,759	Year 5 Estimated Outcome Amount: $703,516
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,666,662			

Title of Outcome Measure (Improvement Target): **IT-10.7 Other Outcome Improvement Target: Physical functional status: mean change score in patients' mobility following physical therapy intervention as assessed using the Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL) Instrument.**

Unique RHP Outcome Identification Number: **307549301.3.31**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

To evaluate the quality of its non-surgical musculoskeletal services, many of which will be provided by physical therapists, the CCC will assess mean change scores in patients' mobility following physical therapy intervention as assessed using the Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL) Instrument. More detailed information on this measure is available at the following link:

http://www.qualitymeasures.ahrq.gov/content.aspx?id=26749&search=functional+status+assessment#Section566

Numerator: Mean change score in CCC patients' mobility following physical therapy intervention as assessed using the OPTIMAL Instrument.
Denominator: Adolescent (?) and adult CCC patients who received physical therapy services at a participating clinic and who completed both a baseline and follow-up OPTIMAL Instrument.

Process Milestones for Each Year

DY 2: P-1 Project Planning: Develop a care protocol to incorporate the use of the OPTIMAL instrument into standard operating procedures for CCC physical therapists.

DY 3: P-3 Develop and test data systems: Ensure CCC data systems are programmed to incorporate and analyze data from the OPTIMAL instrument.

P-2 Establish baseline rate.

P-7 Establish improvement target.

DY 4:

DY 5:

Outcome Improvement Targets for Each Year:

DY 2:

DY 3:

DY 4: Improve mean change score in CCC patients' mobility following physical therapy intervention as assessed using the OPTIMAL Instrument by TBD%.

DY 5: Improve mean change score in CCC patients' mobility following physical therapy intervention as assessed using the OPTIMAL Instrument by TBD%.

Related Category 1 and Category 2 Unique RHP Project Identifiers
307459301.1.5 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Because physical therapy is a new service for the CCC and its patients, the CCC will develop a care protocol in DY 2 that will incorporate OPTIMAL Instrument data collection into standard operating procedures for physical therapy services. Early in DY 3, the CCC will work to ensure OPTIMAL data elements are included in the CCC's data systems in order to aggregate and analyze outcome measure data. In DY 3, the CCC will establish a baseline rate and improvement targets to be measured by OPTIMAL for CCC patients who receive physical therapy services. In DY 4 and 5, CCC patients are expected to see improvements in their mobility as measured by this tool, hence the selection of this improvement target.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project expands access to non-surgical musculoskeletal services, including physical therapy. The physical therapist in the CCC's network will incorporate the OPTIMAL Instrument into his or her standard practice to evaluate patient improvements. The addition of physical therapy services for the CCC population are expected to achieve improved mobility for the patient population as measured by OPTIMAL.

Outcome Measure Valuation

Approach for Valuing Outcome Measure* and *Rationale/Justification for Valuation

In valuing its projects, the Community Care Collaborative considered the overall value of the related Category 1 project and the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307549301.3.31	*3.IT-10.7*	*Other Outcome Improvement Target - Physical functional status: mean change score in patients' mobility following physical therapy intervention as assessed using the Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL) Instrument.*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.5 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions*		
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: Develop a care protocol to incorporate the use of the OPTIMAL instrument into standard operating procedures for CCC physical therapists. Data Source: Documentation of clinical protocols incorporating these elements. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $226,130	**Process Milestone 2** [P-3]: Develop and test data systems - Ensure CCC data systems are programmed to incorporate and analyze data from the OPTIMAL instrument. Data Source: CCC EHR Process Milestone 2 Estimated Incentive Payment: $106,085 **Process Milestone 2** [P-2]: Establish a baseline rate. Data Source: CCC EHR Process Milestone 2 Estimated	**Outcome Improvement Target 1** [IT-1.1]: Improve mean change score in CCC patients' mobility following physical therapy intervention as assessed using the OPTIMAL Instrument by TBD%. Improvement Target: TBD% Data Source: CCC EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $418,760	**Outcome Improvement Target 2** [IT-1.1]: Improve mean change score in CCC patients' mobility following physical therapy intervention as assessed using the OPTIMAL Instrument by TBD%. Improvement Target: TBD% Data Source: CCC EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $703,516

307549301.3.31	*3.IT-10.7*	*Other Outcome Improvement Target - Physical functional status: mean change score in patients' mobility following physical therapy intervention as assessed using the Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL) Instrument.*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.5 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions*		
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)**
	Incentive Payment: $106,086 **Process Milestone 3 [P-7]:** Establish an improvement target. Data Source: CCC EHR Process Milestone 3 Estimated Incentive Payment: $106,086		
Year 2 Estimated Outcome Amount: $226,130	Year 3 Estimated Outcome Amount: $318,257	Year 4 Estimated Outcome Amount: $418,760	Year 5 Estimated Outcome Amount: $703,516
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,666,663			

Title of Outcome Measure (Improvement Target): **IT-1.1 Third Next Available Appointment**

Unique RHP Outcome Identification Number: 307459301**.3.6**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

Average length of time in days between the day a patient makes a request for an appointment with a gastroenterologist and the third available appointment for a new patient, routine exam, or return visit exam. This project will reduce the number of days until the third next available appointment to see a gastroenterologist.

Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit with a gastroenterologist in the CCC's network.

Denominator: This measure applies to providers within the CCC.

As part of this measure, the CCC will track and report on two wait times until third next available appointment: General GI services and GI liver services.

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to assess to determine targets for number of days to decrease third next available appointments time and establish a composite baseline across all CCC providers for each measure – General GI and GI Liver.

DY 3:

DY 4:

DY 5:

Outcome Improvement Targets for Each Year:

DY 2:

DY 3: **Decrease the number of days until the third next available gastroenterology appointment by TBD %**

DY 4: **Decrease the number of days until the third next available gastroenterology appointment by TBD %**

DY 5: **Decrease the number of days until the third next available gastroenterology appointment by TBD %**

Related Category 1 Unique RHP Project Identifiers

307459301.1.6 Expand Specialty Care Capacity for Gastroenterology

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Third next available appointment is the standard measure to understand how quickly a patient can access needed care. The overall goal of the project is to achieve improved access to gastroenterology services, for both general GI care and GI liver care. Improvement in this measure should result in improved access.
In DY 2, the CCC will develop a composite measure across all CCC GI general providers and GI liver providers to gain the most accurate assessment wait times until third next available appointment. In DYs 3,4, and 5, the CCC will monitor improvements in the outcome improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The Category 1 project anticipates hiring additional GI providers and providing additional GI visits in DY 2 and 3. Therefore, the CCC expects that the time until third next available appointment should decrease beginning in DY 3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project increases the number of gastroenterologists available to serve the target population. Increasing the number of providers will increase the number of appointment slots available. With more appointment slots available, the amount of time until the third next available gastroenterology appointment is expected to decrease.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.6	*3.IT-1.1*	*Third Next Available Appointment*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.6 Expand Specialty Care Capacity for Gastroenterology*		
Starting Point/Baseline:	*GI=124 days, GI Liver=314 days*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process Data Source: Documentation of a planning process to determine appropriate targets for reduced time until third next available appointment. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $199,760	**Outcome Improvement Target 1** [IT-1.1]: Decrease number of days until third next available gastroenterology appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 1 Estimated Incentive Payment*:* $281,143	**Outcome Improvement Target 2** [IT-1.1]: Decrease number of days until third next available gastroenterology appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 2 Estimated Incentive Payment*:* $369,926	**Outcome Improvement Target 3** [IT-1.1]: Decrease number of days until third next available gastroenterology appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 3 Estimated Incentive Payment*:* $621,475
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $199,760	Year 3 Estimated Outcome Amount: $281,143	Year 4 Estimated Outcome Amount: $369,926	Year 5 Estimated Outcome Amount: $621,475
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,472,304			

Title of Outcome Measure (Improvement Target): IT-1.8: Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134)

Unique RHP Outcome Identification Number: 307459301.3.7

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

Depression is common among patients with Hepatitis C and this condition may worsen during treatment. Screening for depression before treatment is crucial and may improve treatment outcomes. (Papafragkakis et al. "Depression and pegylated interferon-based hepatitis C treatment" *International Journal of Interferon, Cytokine, and Mediator Research.* March 2012, Volume: 2012:4, Pages 25-35). The CCC's goal is to ensure all patients diagnosed with hepatitis C are screened for depression and follow-up plan is documented. Identifying and treating depression in hepatitis C patients is expected to improve adherence to treatment protocols.

Numerator: CCC patients 18 years of age and older newly diagnosed with HCV and screened for depression and follow up plan is documented.
Denominator: CCC patients 18 years of age and older newly diagnosed with HCV.

Process Milestones for Each Year

DY 2: P-1 Project Planning. Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. CCC GI providers and other stakeholders will devise a care delivery approach that integrates depression screening into the regular care for patients newly diagnosed with HCV, including which screening measure is most appropriate.

DY 3: P-3: Develop and test data systems to capture depression screening data for people diagnosed with HCV.

P-2: Establish a baseline rate of the existing number of HCV patients who are screened for depression.

P-7: Establish an improvement target for the increased percentage of HCV patients who are screened and have a documented treatment plan for depression.

DY 4:

DY 5:

Outcome Improvement Targets for Each Year:

DY 2:

DY 3:

DY 4: Improve the rate of HCV patients who are screened for depression and have a documented treatment plan by TBD%.

DY 5: Improve the rate of HCV patients who are screened for depression and have a documented treatment plan by TBD%.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.6 Expand Specialty Care Capacity for Gastroenterology

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

In DY 2, GI providers and CCC staff will conduct a planning process to devise a care delivery approach that integrates depression screening into the regular care for patients newly diagnosed with HCV, including which screening measure is most appropriate. Depression screening will need to be developed as a standard practice in HCV treatment, and the most effective strategies to incorporate it into this delivery system will be determined in this year.
In DY 3, based on the planning process, the CCC will develop and test data systems necessary to measure and monitor progress the rate of depression screening among HCV patients. The CCC will also establish a depression screening baseline and improvement targets to be achieved in DY 4 and 5.

In DY 4 and 5, the CCC will improve the rate of depression screening for newly-diagnosed HCV patients. Depression screening and treatment, if necessary, is an important step toward keeping HCV patients on track with their HCV treatment plans.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.
N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
The related Category 1 project will expand access to care for gastroenterology services, including care for people needing treatment for hepatitis C. As part of this treatment, providers will incorporate into their standard practice the screening of newly diagnosed hepatitis C patients for depression and document a follow up plan. By incorporating this work as standard practice in hepatitis C treatment, the percentage of hepatitis C patients screened for depression is expected to increase.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.7	*3.IT-1.8*	*Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134)*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.6 Expand Specialty Care Capacity for Gastroenterology*		
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 – Devising the best way to integrate depression screening into HCV patient care Data Source: Written documentation of care plans. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $99,880	**Process Milestone 2 [P-3]** Develop and test data systems Data Source: CCC EHR Process Milestone 2 Estimated Incentive Payment: $46,858 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: CCC EHR Process Milestone 3 Estimated Incentive Payment: $46,857 **Process Milestone 4** [P-7]: Establish improvement targets Data Source: CCC EHR Process Milestone 4 Estimated Incentive Payment: $46,857	**Outcome Improvement Target 1** [IT-1.8]: Improve the rate of HCV patients who are screened for depression and have a documented treatment plan. Improvement Target: TBD% Data Source: CCC EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $184,963	**Outcome Improvement Target 2** [IT-1.8]: Improve the rate of HCV patients who are screened for depression and have a documented treatment plan. Improvement Target: TBD% Data Source: CCC EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $310,738
Year 2 Estimated Outcome Amount: $99,880	Year 3 Estimated Outcome Amount: $140,572	Year 4 Estimated Outcome Amount: $184,963	Year 5 Estimated Outcome Amount: $310,738
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $736,153			

Title of Outcome Measure (Improvement Target): **IT-1.20 Other Outcome Improvement Target: Monitoring adherence to treatment protocols for patients on prescribed medication therapy – boceprevir or telaprevir in combination with peginterferon alfa and ribavirin (Class 1, Level A)**[150]

Unique RHP Outcome Identification Number: **307459301.3.8**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

This project will measure the success of the provider to ensure patients treated for Hepatitis C adhere to their treatment regimens as follows:

Percentage of patients 18 years of age and older who received a minimum of 12-24 weeks of HCV treatments.

Numerator: CCC patients 18 years of age and older with a minimum of 12-24 weeks of HCV treatments.

Denominator: CCC patients 18 years of age and older newly diagnosed with HCV.

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to determine the most effective methodology for tracking patient adherence to these medications.

DY 3: P-3 Develop and test data systems: The performing provider will incorporate tracking data related to HCV medication adherence into the CCC's health information exchange. The provider will test the validity and reliability of the data in this year.

P-2 Establish baseline rates: The performing provider will use the health information exchange to determine a baseline rate for HCV treatment adherence. This process will also produce an improvement target for the CCC to achieve in DYs 4 and 5.

DY 4:

DY 5:

Outcome Improvement Targets for Each Year:

DY 2:

DY 3:

DY 4: **Improve the percentage of patients who received at least 24 weeks of HCV treatments by TBD %**

DY 5: **Improve the percentage of patients who received at least 24 weeks of HCV treatments by TBD %**

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[150] American Association for the Study of Liver Diseases – 2011 Practice Guideline. http://www.aasld.org/practiceguidelines/Documents/2011UpdateGenotype1HCVbyAASLD24641.pdf The drug combination noted here is recommended for patients who have never received therapy for HCV.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.6 Expand Specialty Care Capacity for Gastroenterology

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The drug combination is recommended by the American Association for the Study of Liver Diseases to be the optimal treatment for people with HCV infection who have never received treatment, and yet these drugs are difficult to take due to side effects. In DY 2, this project will determine the best method to document and monitor treatment adherence to drug combinations that treat newly diagnosed HCV patients. In DY 3, the project will develop and test data systems to capture this information and develop baselines and improvement targets to measure improvement. In DY 4 and 5, the project will see improvement in adherence to treatment protocols by HCV patients, with a goal of reducing the HCV disease burden among the population.
The other outcome improvement target option was chosen because there were no other relevant measures to track medication monitoring and adherence to HCV treatment drugs.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Expanding access to gastroenterology services in general, as well as gastroenterology liver services, will allow the CCC to see more people in a more timely way who have been diagnosed with Hepatitis (HCV). Because treatment is expected to be more accessible and timely, improved medication management should occur. With improved medication management, patients should be able to better adhere to their medications.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.8	*3.IT-1.20*	*Other Outcome Improvement Target: Monitoring for patients on prescribed medication therapy*: *boceprevir or telaprevir in combination with peginterferon alfa & ribavirin (Class 1, Level A)*[151]	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.6 Expand Specialty Care Capacity for Gastroenterology*		
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: Documentation of a plan to monitor and improve adherence to HCV treatment regimens. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $99,880	**Process Milestone 2** [P-3]: Develop and test data systems Data Source: CCC health information exchange Process Milestone 2 Estimated Incentive Payment: $70,286 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: CCC health information exchange Process Milestone 2 Estimated Incentive Payment: $70,286	**Outcome Improvement Target 1** [IT-1.20]: Other Outcome Improvement Target: Annual monitoring for patients on persistent medications Improvement Target: TBD% Data Source: CCC health information exchange Outcome Improvement Target 2 Estimated Incentive Payment*:* $184,963	**Outcome Improvement Target 2** [IT-1.20]: Other Outcome Improvement Target: Annual monitoring for patients on persistent medications Improvement Target: TBD% Data Source: CCC health information exchange Outcome Improvement Target 2 Estimated Incentive Payment*:* $310,738
Year 2 Estimated Outcome Amount:: $99,880	Year 3 Estimated Outcome Amount: $140,572	Year 4 Estimated Outcome Amount: $184,963	Year 5 Estimated Outcome Amount: $310,738
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $736,153			

[151] American Association for the Study of Liver Diseases – 2011 Practice Guideline. http://www.aasld.org/practiceguidelines/Documents/2011UpdateGenotype1HCVbyAASLD24641.pdf The drug combination noted here is recommended for patients who have never received therapy for HCV.

Title of Outcome Measure (Improvement Target): **IT-12.3 Colorectal Cancer Screening (HEDIS 2012)**

Unique RHP Outcome Identification Number: **307459301.3.9**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

Numerator: Number of adults aged 50-75 that have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, colonoscopy every ten years.
Denominator: Number of adults aged 50-75 in the CCC population. Adults with colorectal cancer or total colectomy are excluded.
Data source: EHR, claims
Rationale: Colon cancer is among the top three cancer-related deaths in Travis County. Adequate prevention measures taken for the target population may reduce the incidence of colon cancer, thus improving health outcomes and lowering health system costs overall.

Process Milestones for Each Year

DY 2:

P-1 Project Planning – Engage stakeholders, identify current capacity, and needed resources. This planning process will allow CCC providers to develop a standard data collection method for this outcome measure, including the appropriate measures to use to track progress.

DY 3:

P-2 Establish baseline rates. Baseline rates will be established to determine how many CCC adults received colorectal cancer screening, based on the data systems and measures developed in DY 2.

P-7 Establish improvement targets. CCC providers will work together to establish improvement targets for the entire CCC population through collaborative processes.

DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: **Increase the rate of colorectal cancer screening in the target population by TBD%**
DY 5: **Increase the rate of colorectal cancer screening in the target population by TBD%**

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.6 Expand Specialty Care Capacity for Gastroenterology

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Monitoring colorectal cancer screening across the target population in a consistent, uniform manner will require planning and coordination among the various providers offering this service. DY 2 will be spent planning a uniform data collection process for this measure. DY 3 will implement this process by first establishing baseline rates of colorectal cancer screening and establishing improvement targets for DYs 4 and 5. The CCC aims to increase the rate of people in the target population who have been screened for colorectal cancer by increasing capacity for GI services in the community, hence the choice of this improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

N/A

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Expansion of GI specialty care in community-based settings will provide additional opportunity for the target population to receive colorectal cancer screenings at the Southeast Health and Wellness Center and through contracted arrangements in the community. Additional opportunities for screening are expected to produce a greater rate of screening among the target population.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.9	*3.IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.6 Expand Specialty Care Capacity for Gastroenterology*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning – Engage stakeholders to determine best way to collect data and which measures to use. Data Source: Documentation of planning meetings. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $199,760	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: CCC patient records Process Milestone 2 Estimated Incentive Payment: $140,572 **Process Milestone 3** [P-7]: Establish improvement targets. Data Source: CCC patient records Process Milestone 3 Estimated Incentive Payment: $140,571	**Outcome Improvement Target 1** [IT-12.3]: Increase the rate of colorectal cancer screening in the target population. Improvement Target: TBD% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $369,926	**Outcome Improvement Target 3** [IT-12.3]: Increase the rate of colorectal cancer screening in the target population. Improvement Target: TBD% Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $621,475
Year 2 Estimated Outcome Amount:: $199,760	Year 3 Estimated Outcome Amount: $281,143	Year 4 Estimated Outcome Amount: $369,926	Year 5 Estimated Outcome Amount: $621,475
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,472,304			

CATEGORY 3 OUTCOME MEASURE NARRATIVE

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5**

Unique RHP Outcome Identification Number: **307459301.3.10**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5. The performing provider's goal is to reduce potentially preventable hospital admissions for this diagnosis to avoid health system costs and improve the health of the patient population. Following cardiovascular disease and cancer, COPD is one of the leading causes of death in Region 7, according to the Texas Department of State Health Services. In addition, COPD is one of the leading contributors of potentially preventable hospitalization costs in Region 7 from 2005-2010, according to the State of Texas Preventable Hospitalizations Profile.

Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD.
Denominator: Population served by the Community Care Collaborative 18 years of age and older.
Data Source: EHR, Claims
Rationale/Evidence: From the Category 3 Protocol, this link shows specific diagnoses to be tracked and which to exclude: http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2005%20Chronic%20Obstructive%20Pulmonary%20Disease%20(COPD)%20Admission%20Rate.pdf

Process Milestones for Each Year

DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The project will conduct a planning process to assess the optimal way to capture admission rates for COPD across the population served.

DY 3: P-2 Establish baseline admissions rate for COPD. The project will analyze COPD hospital admissions for the target population to determine a baseline admission rate on which to improve. This process will also establish an improvement target for improvement in COPD admissions.

P-3 Develop and test data systems. The project will incorporate COPD admission data capturing into the performing provider's health information exchange system.

DY 4:

DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3:
DY 4: Decrease number of admissions for COPD by TBD%.
DY 5: Decrease number of admissions for COPD by TBD%.

Related Category 1 and Category 2 Unique RHP Project Identifiers
307459301.1.7

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

During DY 2, the CCC will work with its provider network and its health insurance exchange to develop an accurate methodology for capturing inpatient admissions for COPD for the patients enrolled in the CCC. In DY 3, the CCC will test those systems to ensure accuracy and establish a baseline for COPD admissions from which to improve. These milestones are chosen to ensure that accurate data is available to track success toward the outcome measure.

The CCC expects to achieve improvements in COPD admission rates by TBD% in DY 4 and by an additional TBD% in DY 5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 1 project will expand the number and locations of pulmonology providers available to serve uninsured, underinsured, Medicaid, and Medicare patients. Access to pulmonology services are extremely limited to the target population at this time. Additional providers are expected to increase the provider's ability to treat patients with COPD in a more timely way and on a more regular basis that supports the care management for the patient. This care is expected to treat the patients' COPD before it advances to the need for hospital-based care, thus reducing COPD related hospital admissions.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

Potentially preventable hospitalizations for COPD contributed to almost $90 million in hospital charges in Travis County between 2005 and 2010. Based on estimates from the Texas Department of State Health Services, each COPD hospitalization averted through improved outpatient specialty care access could save approximately $27,616 in average hospital charges.

307459301.3.10	*3.IT-2.5*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.1.7 Increase Specialty Care Capacity for Pulmonology*		
Starting Point/Baseline:	*TBD*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Program documents. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $541,519	**Process Milestone 2** [P-3]: Develop and test data systems Data Source: Electronic health record. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $381,069 **Process Milestone 3** [P-2]: Establish baseline admissions rate and improvement targets for COPD. Data Source: EHR Process Milestone 3 Estimated Incentive Payment: $381,069	**Outcome Improvement Target 2** [IT-2.5]: COPD Admission Rate Improvement Target: Decrease number of admissions for COPD by TBD%. Data Source: Electronic health record, claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,002,813	**Outcome Improvement Target 3** [IT-2.5]: COPD Admission Rate Improvement Target: Decrease number of admissions for COPD by TBD%. Data Source: Electronic health record, claims. Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,684,726
Year 2 Estimated Outcome Amount: $541,519	Year 3 Estimated Outcome Amount: $762,138	Year 4 Estimated Outcome Amount: $1,002,813	Year 5 Estimated Outcome Amount: $1,684,726
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,991,196			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710).

Unique RHP Outcome Identification Number: 307459301.3.11 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710).

Process Milestones

DY2:

- ***P-1 – Project planning*** – Develop and prepare to implement a project plan, including details to gather and analyze individual patient data to aid in program assessment across demonstration years

DY3:

- ***P-2 – Establish baseline rates*** – Establish baseline PHQ-9 Scores

Outcome Improvement Targets for Each Year:

DY 4:

- **IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710) -** At least 10% of individuals receiving tele-mental services for depression will have achieved PHQ-9 scores less than 5

DY 5:

- **IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710) -** At least 30% of individuals receiving tele-mental services will have achieved PHQ-9 scores less than 5

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.1.8

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The need for mental health services in the community is greater than the supply of doctors and thus many low-income, Medicaid patients have mental health needs that go untreated. Forty-three percent of

consumers at a Travis County FQHC were diagnosed with major depression. This project proposes to improve patient's depression symptomatology by providing them access to mental health care via tele-mental services. Improvements will be assessed via the PHQ-9, a depression assessment.

DY2 will be devoted to project planning to ensure maximum project success. The process milestone in DY3 - establishing baseline rates - was selected to so that the impact of the intervention can be measured.

By DYs 4 and 5, we will be able to measure the improvement in the patients affected by their PHQ-9 scores. This is reflected in the two improvement milestones chosen for those years.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
This project provides tele-mental services to individuals assessed to have a mental health condition. Gaining access to mental health care, delivered via tele-mental services for this population is expected to improve their mental health condition.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.11	3.IT-1.9	*Depression Management: Depression Remission at Twelve Months*	
Community Care Collaborative			**307459301**
Related Category 1 or 2 Projects:	**307459301.1.8 Telepsychiatry in Community Based Clinics**		
StartingPoint/Baseline:	New program: enrollment begins 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 - Develop and prepare to implement a project plan Data Source: Planning document Process Milestone 1 Estimated Incentive Payment: $ 210,953	**Process Milestone 2** [P-2]: Establish baseline PHQ-9 scores Data Source: Clinic records of patient PHQ-9 scores or administered PHQ-9 scores Process Milestone 2 Estimated Incentive Payment (maximum amount): $ 296,897	**Outcome Improvement Target 1** [IT-1.9] Depression Management: Depression Remission at Twelve Months Improvement Target: At least 10% will have achieved PHQ-9 scores less than 5 Data Source: Patient scores on the PHQ-9 captured in EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 390,653	**Outcome Improvement Target 2** [IT-1.9] Depression Management: Depression Remission at Twelve Months Improvement Target: At least 30% will have achieved PHQ-9 scores of less than 5 Data Source: Patient scores on the PHQ-9 captured in EHR/HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 656,298
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 210,953	Year 3 Estimated Outcome Amount: $ 296,897	Year 4 Estimated Outcome Amount: $ 390,653	Year 5 Estimated Outcome Amount: $ 656,298
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 1,554,801			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): IT-1.20 Other Outcome Improvement Target/Improvements in anxiety

Unique RHP Outcome Identification Number: 307459301.3.12 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

IT-1.20 Other Outcome Improvement Target/Improvements in anxiety

Process Milestones

DY2:

- ***P-1 – Project planning*** – Develop and prepare to implement a project plan, including details to gather and analyze individual patient data to aid in program assessment across demonstration years

DY3:

- ***P-2 – Establish baseline rates***

Outcome Improvement Targets for Each Year:

DY 4:

- **IT-1.20 Other Outcome Improvement Target/Improvements in severity of generalized anxiety disorder as measured by the Generalized Anxiety Disorder (GAD-7) screening tool –** 20% of patients scoring a 10 or higher on the GAD at baseline will demonstrate improvements to a score of 5 or below

DY 5:

- **IT-1.20 Other Outcome Improvement Target/Improvements in severity of generalized anxiety disorder as measured by the Generalized Anxiety Disorder (GAD-7) screening tool –** 35% of patients with scores of 10 or higher on the GAD at baseline will demonstrate improvements to a score of 5 or below.

Related Category 1 and Category 2 Unique RHP Project Identifiers
307459301.1.8

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The need for mental health services in the community is greater than the supply of doctors and thus many low-income, Medicaid patients have mental health needs that go untreated. Anxiety disorders were the second most prevalent cluster of mental disorders, behind mood disorders, for Travis County residents who received care at a local community health clinic. The prevalence of anxiety disorders was 12% of all those with mental health conditions. This project proposes to improve patient's generalized anxiety symptomatology by providing them access to mental health care via tele-mental services. Improvements will be assessed via the GAD-7, an assessment for generalized anxiety disorder. The GAD-7 is a valid and efficient tool for screening for Generalized Anxiety Disorder and measuring severity.

The process milestones in DY2 (project planning) and DY3 (establish baseline rates) were selected to prepare for implementation. DY2 planning work includes developing clinical protocols prior, identifying the type and amount of equipment to purchase. Currently, no clinic is equipped to engage in tele-mental services and clinical protocols for referral, clinical oversight, and mechanisms for physician to tele-mental provider collaborations have been developed. Because this project involves a network of community-based primary care clinics, accurately and thoroughly evaluating the unique characteristics of each setting is important. Complex issues of interface will need to be addressed prior to service delivery so the need for a gradual phase-in of operations was recognized as essential. Baseline rates will be established in DY3; as patients are enrolled in the program, the CCC will track demand for tele-mental services based on available resources at the time to ensure the ability to project resource needs in the future to scale up the project.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.
This project provides tele-mental services to individuals assessed to have a mental health condition. Gaining access to mental health care, delivered via tele-mental services for this population is expected to improve their mental health condition.

Outcome Measure Valuation

Valuing Outcome Measures
In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.12	3.IT-1.20	*Other Outcome Improvement Target – Improvements in severity of generalized anxiety disorder as measured by the Generalized Anxiety Disorder (GAD-7) screening tool*	
Performing Provider: Community Care Collaborative			**307459301**
Related Category 1 or 2 Projects:	**307459301.1.8 Telepsychiatry in Community Based Clinics**		
Starting Point/Baseline:	Enrollment begins 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 - Develop and prepare to implement a project plan Data Source: Planning document Process Milestone 1 Estimated Incentive Payment: $ 210,952	**Process Milestone 2** [P-2]: Establish baseline rates – GAD-7 Scores Data Source: EHR/HIE Process Milestone 2 Estimated Incentive Payment (maximum amount): $ 296,896	**Outcome Improvement Target 1** [IT-1.20] Other Outcome Improvement Target: Improvements in patients GAD-7 scores to a score of 5 or below. Target: 20% of patients scoring a 10 or higher on the GAD at baseline will demonstrate improvements to a score of 5 or below Data Source: EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 390,653	**Outcome Improvement Target 2** [IT-1.20] Other Outcome Improvement Target/Improvements in patients GAD-7 scores to a score of 5 or below. Improvement Target: 35% of patients scoring a 10 or higher on the GAD at baseline will demonstrate improvements to a score of 5 or below Data Source: EHR/HIE 2 Estimated Incentive Payment*:* $ 656,297
Year 2 Estimated Outcome Amount: $ 210,952	Year 3 Estimated Outcome Amount: $ 296,896	Year 4 Estimated Outcome Amount: $ 390,653	Year 5 Estimated Outcome Amount: $ 656,297
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 1,554,798			

CATEGORY 3 OUTCOME MEASURE NARRATIVE

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-6.1 – Percent Improvement over Baseline of Patient Satisfaction Scores**

Unique RHP Outcome Identification Number: 307459301.3.13
Performing Provider Name: **Community Care Collaborative (CCC)**

Performing Provider TPI : 307459301

Outcome Measure Description

Overall Outcome Measure Description

IT-6.1- Percent Improvement over Baseline of Patient Satisfaction Scores

The percent of patients surveyed on the CG-CAHPs survey reporting satisfaction in one or more of the targeted domains.

Process Milestones for Each Year

DY 2:

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

DY 3:

P-3 -- Develop and test data systems
P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-2 -- Establish baseline IT rate
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

DY 4:

P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

DY5:

P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets for Each Year:

DY 4:

IT6.1 -- Percent Improvement over Baseline of Patient Satisfaction Scores. Increase in percent of patient satisfaction scores in one or more of the targeted domains on the CG-CAHPs survey by TBD over baseline.

DY 5:

IT6.1 -- Percent Improvement over Baseline of Patient Satisfaction Scores. Increase in percent of patient satisfaction scores in one or more of the targeted domains on the CG-CAHPs survey by TBD over baseline.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.2.1

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Process Milestone 1 (Project Planning, in DY2) was selected to ensure that the CCC will be able to implement well and fully this important data gathering exercise.

Process Milestones 3 (Develop and Test Systems) and 2 (Establish Baseline Rates) were selected for DY3 to lay the groundwork for collecting data both from patients and from provider systems and establish a baseline for patient satisfaction across the CCC.

Process Milestone 4 (Conduct PDSA cycles) was selected across DY3-5 to monitor and improve effectiveness of data collection. Process Milestone 5 was similarly selected across DY3-5 to share patient satisfaction data between providers and, critically, with patients.

Improvement Target 6.1, Percent Improvement over Baseline of Patient Satisfaction Scores was selected to help providers obtain the patient's perspective on care and allows for objective comparisons across institutions and time in areas of importance to consumers.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The specific percentage increase for the Improvement Target will be set during DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

It is anticipated that the implementation of a PCMH model of care across the CCC network will allow for increased access to more comprehensive and timely services in the medical home based on enhanced data access and multi-disciplinary approaches to patient care needs which should reduce preventable hospital admissions.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.13	IT-6.1.1	Percent improvement over baseline of patient satisfaction scores	
Community Care Collaborative			307459301
Related Category 1 or 2 projects :	307459301.2.1 Patient Centered Medical Homes		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Implementation Plan Planning Milestone 1 Estimated Incentive Payment *(maximum amount):* $316,475	**Process Milestone 2** [P-3]: Develop and test data systems. Data Source: HIE Process Milestone 2 Estimated Incentive Payment: $111,352 **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: HIE Process Milestone 3 Estimated Incentive Payment: $111,352 **Process Milestone 4** [P-2]: Establish baseline rates Data Source: HIE Process Milestone 4 Estimated Incentive Payment: $111,352 **Process Milestone 5** [[P-5]: Disseminate findings, including lessons learned and best practice, to stakeholders	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target: Increase in percent of patient satisfaction scores in one or more of the targeted domains on the CG-CAHPs survey by TBD over baseline. Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment: $195,355 **Process Milestone 6** [P-5]: Disseminate findings, including lessons learned and best practice, to stakeholders Data Source: HIE, EHR Process Milestone 6 Estimated Incentive Payment: $195,355 **Process Milestone 7** [P-4]: Conduct Plan Do Study Act	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target: Increase in percent of patient satisfaction scores in one or more of the targeted domains on the CG-CAHPs survey by TBD over baseline. Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment: $328,196 **Process Milestone 8** [P-5]: Disseminate findings, including lessons learned and best practice, to stakeholders Data Source: HIE, EHR Process Milestone 2 Estimated Incentive Payment: $328,196 **Process Milestone 9** [P-4]:

307459301.3.13	IT-6.1.1	Percent improvement over baseline of patient satisfaction scores	
Community Care Collaborative			307459301
Related Category 1 or 2 projects :	307459301.2.1 Patient Centered Medical Homes		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: HIE, EHR Process Milestone 5 Estimated Incentive Payment: $111,353	(PDSA) cycles to improve data collection and intervention activities Data Source: HIE Process Milestone 7 Estimated Incentive Payment: $195,355	Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: HIE Process Milestone 3 Estimated Incentive Payment: $328,196
Year 2 Estimated Outcome Amount: $316,475	Year 3 Estimated Outcome Amount: $445,409	Year 4 Estimated Outcome Amount: $586,065	Year 5 Estimated Outcome Amount: $984,588
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,332,537			

Title of Outcome Measure (Improvement Target): **IT-1.1 Third Next Available Appointment**

Unique RHP Outcome Identification Number: 307459301**.3.32**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

Average length of time in days between the day a patient makes a request for an appointment with any provider in the CCC network and the third available appointment for a new patient, routine exam, or return visit exam. This project will reduce the number of days until the third next available appointment to see a provider.

Numerator: Average number of days to third next available appointment for a new patient physical, routine exam, or return visit with a provider in the CCC's network.

Denominator: This measure applies to providers within the CCC.

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to determine targets for number of days to decrease third next available appointment time and establish a baseline for each/across all CCC providers for the measure.

DY 3:

DY 4:

DY 5:

Outcome Improvement Targets for Each Year:

DY 2:

DY 3: Decrease the number of days until the third next available appointment by TBD %

DY 4: Decrease the number of days until the third next available appointment by TBD %

DY 5: Decrease the number of days until the third next available appointment by TBD %

Related Category 1 Unique RHP Project Identifiers

307459301.2.1 The Community Care Collaborative's Patient Centered Medical Home Model

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Third next available appointment is the standard measure to understand how quickly a patient can access needed care, a foundational metric of the Patient Centered Medical Home model which this project will

establish throughout its entire network of providers. Reducing the time to third next available appointment can: provide easy access for established patients; increase availability for new patients; improve continuity of care; increase patient satisfaction; and reduce ED usage, among other benefits.

In DY 2, the CCC will develop the baseline for third next available across all CCC primary care providers. In DYs 3, 4, and 5, the CCC will monitor improvements in the outcome improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The Improvement targets will be determined in DY2.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 2 project requires all providers in the CCC's network to adopt certain PCMH principles. One chief measure of a practice's patient centeredness is the time to the third next available appointment.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.32	*3.IT-1.1*	*Third Next Available Appointment*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.1: The Community Care Collaborative's Patient Centered Medical Home*		
Starting Point/Baseline:	*TBD in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process Data Source: Documentation of a planning process to establish baseline and determine appropriate targets for reduced time until third next available appointment. Process Milestone 1 Estimated Incentive Payment*:* $316,475	**Outcome Improvement Target 1** [IT-1.1]: Decrease number of days until third next available appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 1 Estimated Incentive Payment*:* $445,409	**Outcome Improvement Target 2** [IT-1.1]: Decrease number of days until third next available appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 2 Estimated Incentive Payment*:* $586,045	**Outcome Improvement Target 3** [IT-1.1]: Decrease number of days until third next available appointment. Improvement Target: TBD Data Source: CCC appointment records Outcome Improvement Target 3 Estimated Incentive Payment*:* $984,589
Year 2 Estimated Outcome Amount:: $ 316,475	Year 3 Estimated Outcome Amount: $445,409	Year 4 Estimated Outcome Amount: $586,045	Year 5 Estimated Outcome Amount: $984,589
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,332,538			

Title of Outcome Measure (Improvement Target): **IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012): angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)**

Unique RHP Outcome Identification Number: 307459301**.3.33**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

Percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Numerator: Members from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Denominator: Members 18 years of age and older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) -- defined as members who received at least 180 treatment days of ambulatory medication during the measurement year.

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to determine annual monitoring rates for the CCC's contracted providers. This planning process will also establish targets for improvement in monitoring rates.
DY 3:
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3: Improve annual monitoring for patients on ACE inhibitors or ARBs by TBD.
DY 4: Improve annual monitoring for patients on ACE inhibitors or ARBs by TBD.
DY 5: Improve annual monitoring for patients on ACE inhibitors or ARBs by TBD.

Related Category 1 Unique RHP Project Identifiers

307459301.2.1 The Community Care Collaborative's Patient Centered Medical Home Model

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Annual monitoring of patients on persistent medication is a critical component of good patient care. This Improvement Target, which aims to *increase the percentage of the CCC's patient population 18 and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year*, represents a commitment to quality care that the CCC will achieve through its PCMH model. A large portion of the CCC's total patient population has conditions that could be treated through ACE inhibitors or ARBs.

In DY 2, the CCC will develop the baseline annual monitoring rate across all CCC primary care providers. In DYs 3, 4, and 5, the CCC will monitor improvements in the outcome improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The Improvement targets will be determined in DY2.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 2 project requires all providers in the CCC's network to adopt certain PCMH principles. One good indicator of a practice's patient centeredness is its medication management policies. Appropriate policies to ensure better health outcomes through quality measures will be adopted by the CCC's network as part of the PCMH project.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.33	*3.IT-1.2*	*Annual monitoring for patients on ACE inhibitors or ARBs*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.1: The Community Care Collaborative's Patient Centered Medical Home*		
Starting Point/Baseline:	*TBD in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process Data Source: Documentation of a planning process to determine annual monitoring of patients on ACE inhibitors or ARBs and appropriate targets for improvement. Process Milestone 1 Estimated Incentive Payment*:* $158,238	**Outcome Improvement Target 1** [IT-1.2]: Increase annual monitoring of patients on ACE inhibitors or ARBs Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $222,706	**Outcome Improvement Target 2** [IT-1.2]: Increase annual monitoring of patients on ACE inhibitors or ARBs Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $293,033	**Outcome Improvement Target 3** [IT-1.2]: Increase annual monitoring of patients on ACE inhibitors or ARBs Improvement Target: TBD Data Source: EHR/Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $492,296
Year 2 Estimated Outcome Amount:: $158,238	Year 3 Estimated Outcome Amount: $222,706	Year 4 Estimated Outcome Amount: $293,033	Year 5 Estimated Outcome Amount: $492,296
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,166,273			

Title of Outcome Measure (Improvement Target): **IT-1.13 Diabetes Care: Foot exam (NQF 0056)**

Unique RHP Outcome Identification Number: 307459301**.3.34**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.

Numerator: Members from the denominator who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.

Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

Process Milestones for Each Year

DY 2: P-1 Project Planning: The performing provider will complete a planning process to determine current annual foot check rates for the CCC's contracted providers. This planning process will also establish targets for improvement in monitoring rates.
DY 3:
DY 4:
DY 5:

Outcome Improvement Targets for Each Year:

DY 2:
DY 3: Improve annual rates of foot checks for patients with type 1 or type 2 diabetes by TBD.
DY 4: Improve annual rates of foot checks for patients with type 1 or type 2 diabetes by TBD.
DY 5: Improve annual rates of foot checks for patients with type 1 or type 2 diabetes by TBD.

Related Category 1 Unique RHP Project Identifiers

307459301.2.1 The Community Care Collaborative's Patient Centered Medical Home Model

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Foot ulcers and amputations are a major cause of morbidity, disability, and emotional and physical costs for people with diabetes (American Diabetes Association). Early recognition and management of risk factors for ulcers and amputations can prevent or delay the onset of more serious complications. All individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions.

In DY 2, the CCC will develop the baseline for third next available across all CCC primary care providers. In DYs 3, 4, and 5, the CCC will monitor improvements in the outcome improvement target.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The Improvement targets will be determined in DY2.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 2 project requires all providers in the CCC's network to adopt certain PCMH principles. These principles emphasize patient self-management, patient empowerment, and team-based care. For the many diabetics who are part of the CCC's population, annual foot exams are both a medical necessity and an opportunity for self-management. The properly delivered foot exam will tend to a patient's medical needs and teach the patient how to evaluate and manage his condition through monitoring of foot sensation, callus development, and general foot health.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.34	*3.IT-1.13*	*Diabetes care: Foot exam*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.1: The Community Care Collaborative's Patient Centered Medical Home*		
Starting Point/Baseline:	*TBD in DY2*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process Data Source: Documentation of a planning process to determine rates of annual foot checks for diabetic patients and appropriate targets for improvement. Process Milestone 1 Estimated Incentive Payment*:* $158,238	**Outcome Improvement Target 1** [IT-1.13]: Increase rate of annual foot checks of patients with diabetes Improvement Target: TBD Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $222,706	**Outcome Improvement Target 2** [IT-1.13]: Increase rate of annual foot checks of patients with diabetes Improvement Target: TBD Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $293,033	**Outcome Improvement Target 3** [IT-1.13]: Increase rate of annual foot checks of patients with diabetes Improvement Target: TBD Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $492,295
Year 2 Estimated Outcome Amount:: $158,238	Year 3 Estimated Outcome Amount: $222,706	Year 4 Estimated Outcome Amount: $293,033	Year 5 Estimated Outcome Amount: $492,295
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,166,272			

Title of Outcome Measure (Improvement Target): **IT-1.6 – Cholesterol Management for Patients with Cardiovascular Conditions**
Unique RHP Outcome Identification Number: 307459301.3.14
Performing Provider Name: **Community Care Collaborative (CCC)**
Performing Provider TPI : 307459301

Outcome Measure Description

Overall Outcome Measure Description

IT-1.6 – Cholesterol Management for Patients with Cardiovascular Conditions

The percent of patients aged 18 to 75 years of age as of December 31 of the measurement year who had an LDL-C Level of < 100 mg/dL or less.

Process Milestones for Each Year

DY 2:

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

DY 3:

P-3 -- Develop and test data systems
P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-2 -- Establish baseline IT rate
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

DY 4:

P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

DY5:

P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets for Each Year:

DY 4:

IT-1.6 -- Cholesterol Management for Patients with Cardiovascular Conditions. Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year who had an LDL-C Level of 100 mg/dL or less by TBD over baseline.

DY 5:

IT-1.6 -- Cholesterol Management for Patients with Cardiovascular Conditions. Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year who had an LDL-C Level of 100 mg/dL or less by TBD over baseline.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.2.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Process Milestone 1 (Project Planning, in DY2) was selected to ensure that the CCC will be able to collaboratively plan and coordinate the transition to a chronic care model(s) for all providers across its network.

Process Milestones 3 (Develop and Test Systems) and 2 (Establish Baseline Rates) were selected for DY3 to lay the groundwork for collecting data both from patients and from provider systems and establish a baseline for cholesterol management for patients with cardiovascular conditions across the CCC.

Process Milestone 4 (Conduct PDSA cycles) was selected across DY3-5 to monitor and improve effectiveness of chronic care transition and implementation. Process Milestone 5 was similarly selected across DY3-5 to share patient health data between providers and, critically, with patients.

Improvement Target 1.6, Cholesterol Management for Patients with Cardiovascular Conditions was selected due to the potentially severe impact on patient health and quality of life if cholesterol levels are not well managed as well as to ensure treatment is provided in the most cost-effective settings.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The specific percentage increase for the Improvement Target will be set during DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

It is anticipated that the implementation of a CCM model of care across the CCC network will allow for increased access to more patient-centered and timely care services in the medical home based on enhanced data access and multi-disciplinary approaches to patient care needs which should result in better management of patient health status.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

Within this particular project, the improvement target's patient population was considered when allocating value between the three identified outcome improvement targets. An additional consideration was whether the improvement target was well-established as a standard of care.

307459301.3.14	IT-1.6	Cholesterol Management for Patients with Cardiovascular Conditions	
Community Care Collaborative			307459301
Related Category 1 or 2 projects :	307459301.2.2 Chronic Care Management Models		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Implementation Plan Planning Milestone 1 Estimated Incentive Payment *(maximum amount):* $493,342	**Process Milestone 2** [P-3]: Develop and test data systems. Data Source: HIE Process Milestone 2 Estimated Incentive Payment: $173,583 **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: HIE Process Milestone 3 Estimated Incentive Payment: $173,583 **Process Milestone 4** [P-2]: Establish baseline rates Data Source: HIE Process Milestone 4 Estimated Incentive Payment: $173,583 **Process Milestone 5** [[P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: HIE, EHR	**Outcome Improvement Target 1** [IT-1.6]: Cholesterol Management for Patients with Cardiovascular Conditions Improvement Target: Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year who had an LDL-C Level of 100 mg/dL or less by TBD over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment: $304,532 **Process Milestone 6** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: HIE, EHR Process Milestone 6 Estimated Incentive Payment: $304,532 **Process Milestone 7** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: HIE	**Outcome Improvement Target 1** [IT-1.6]: Cholesterol Management for Patients with Cardiovascular Conditions Improvement Target: Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year who had an LDL-C Level of 100 mg/dL or less by TBD over baseline. Data Source: EHR, Registry Outcome Improvement Target 1 Estimated Incentive Payment: $511,614 **Process Milestone 8** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: HIE, EHR Process Milestone 8 Estimated Incentive Payment: $511,614 **Process Milestone 9** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: HIE

307459301.3.14	IT-1.6	Cholesterol Management for Patients with Cardiovascular Conditions	
Community Care Collaborative			307459301
Related Category 1 or 2 projects :	307459301.2.2 Chronic Care Management Models		
Starting Point/Baseline:	To be developed 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 5 Estimated Incentive Payment: $173,584	Process Milestone 7 Estimated Incentive Payment: $304,532	Process Milestone 9 Estimated Incentive Payment: $511,614
Year 2 Estimated Outcome Amount: $493,342	Year 3 Estimated Outcome Amount: $694,333	Year 4 Estimated Outcome Amount: $913,596	Year 5 Estimated Outcome Amount: $1,534,842
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,636,114			

Title of Outcome Measure (Improvement Target): **IT-1.11 – Diabetes Care: Blood Pressure Control**

Unique RHP Outcome Identification Number: 307459301.3.15
Performing Provider Name: **Community Care Collaborative (CCC)**

Performing Provider TPI : 307459301

Outcome Measure Description

Overall Outcome Measure Description

IT-1.11 – Diabetes Care: BP Control

The percent of patients aged 18 to 75 years of age as of December 31 of the measurement year whose most recent blood pressure reading was less than 140/90 mm Hg.

DY 2:

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

DY 3:

P-3 -- Develop and test data systems
P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-2 -- Establish baseline IT rate
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

DY 4:

P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

DY5:

P-4 – Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
P-5 – Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets for Each Year:

DY 4:

IT-1.11 -- Diabetes Care: BP Control. Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year whose most recent blood pressure reading was less than 140/90 mm Hg by TBD over baseline.

DY 5:

IT-1.11 -- Diabetes Care: BP Control. Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year whose most recent blood pressure reading was less than 140/90 mm Hg by TBD over baseline.

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.2.2

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Process Milestone 1 (Project Planning, in DY2) was selected to ensure that the CCC will be able to collaboratively plan and coordinate the transition to a chronic care model(s) for all providers across its network.

Process Milestones 3 (Develop and Test Systems) and 2 (Establish Baseline Rates) were selected for DY3 to lay the groundwork for collecting data both from patients and from provider systems and establish a baseline for cholesterol management for patients with cardiovascular conditions across the CCC.

Process Milestone 4 (Conduct PDSA cycles) was selected across DY3-5 to monitor and improve effectiveness of chronic care transition and implementation. Process Milestone 5 was similarly selected across DY3-5 to share patient health data between providers and, critically, with patients.

Improvement Target 1.11, Blood Pressure Control for Patients with Diabetes was selected due to the potentially severe impact on patient health and quality of life if blood pressure levels are not well managed as well as to ensure treatment is provided in the most cost-effective settings.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

The specific percentage increase for the Improvement Target will be set during DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

It is anticipated that the implementation of a CCM model of care across the CCC network will allow for increased access to more patient-centered and timely care services in the medical home based on enhanced data access and multi-disciplinary approaches to patient care needs which should result in better management of patient health status.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

Within this particular project, the improvement target's patient population was considered when allocating value between the three identified outcome improvement targets. An additional consideration was whether the improvement target was well-established as a standard of care.

307459301.3.15	IT-1.11	Diabetes Care: BP Control	
Community Care Collaborative			307459301
Related Category 1 or 2 projects :	307459301.2.2 Chronic Care Management Models		
Starting Point/Baseline:	To be developed in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Implementation Plan Planning Milestone 1 Estimated Incentive Payment: $493,342	**Process Milestone 2** [P-3]: Develop and test data systems. Data Source: HIE Process Milestone 2 Estimated Incentive Payment: $173,583 **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: HIE Process Milestone 3 Estimated Incentive Payment: $173,583 **Process Milestone 4** [P-2]: Establish baseline rates Data Source: HIE Process Milestone 4 Estimated Incentive Payment: $173,584 **Process Milestone 5** [[P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: HIE, EHR	**Outcome Improvement Target 2** [IT-1.11]: Diabetes Care: BP Control Improvement Target: Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year whose most recent blood pressure test was 140/90 mm Hg or less by TBD over baseline. Data Source: EHR, Registry, Claims, Administrative Clinical Data Outcome Improvement Target 2 Estimated Incentive Payment: $304,532 **Process Milestone 6** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: HIE, EHR Process Milestone 6 Estimated Incentive Payment: $304,532 **Process Milestone 7** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: HIE	**Outcome Improvement Target 2** [IT-1.11]: Diabetes Care: BP Control Improvement Target: Increase in percent of patients aged 18 to 75 years of age as of December 31 of the measurement year whose most recent blood pressure test was 140/90 mm Hg or less by TBD over baseline. Data Source: EHR, Registry, Claims, Administrative Clinical Data Outcome Improvement Target 2 Estimated Incentive Payment: $511,614 **Process Milestone 8** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: HIE, EHR Process Milestone 8 Estimated Incentive Payment *(maximum amount):* $511,614 **Process Milestone 9** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

307459301.3.15	IT-1.11	Diabetes Care: BP Control	
Community Care Collaborative			307459301
Related Category 1 or 2 projects :	307459301.2.2 Chronic Care Management Models		
Starting Point/Baseline:	To be developed 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 5 Estimated Incentive Payment: $173,584	Process Milestone 7 Estimated Incentive Payment: $304,533	Data Source: HIE Process Milestone 9 Estimated Incentive Payment: $511,614
Year 2 Estimated Outcome Amount: $493,342	Year 3 Estimated Outcome Amount: $694,334	Year 4 Estimated Outcome Amount: $913,597	Year 5 Estimated Outcome Amount: $1,534,842
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,636,115			

Title of Outcome Measure (Improvement Target): OD-1 – Primary Care and Chronic Disease Management

IT - 1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710)

Unique RHP Outcome Identification Number: 307459301.3.17 Pass 3

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

The outcome improvement target is depression remission at twelve months (IT-1.9 Depression management: Depression Remission at Twelve Months (NQF #0710).

Process Milestones for Each Year

DY2 – P-1 – Project Planning – Develop and implement a plan for gathering and analyzing individual patient data

DY3 - P-2 – Establish baseline – establish baseline rates for clinical measurements for program participants

Outcome Improvement Targets for Each Year:

DY 4: IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710): 15% of program participants will have achieved lower PHQ-9 scores.

DY 5: IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF #0710): 30% of program participants will have achieved lower PHQ-9 scores.

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.2.3

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Baseline data on two clinical indicators will be measured – program participants' scores on a depression inventory (PHQ-9) and hemoglobin A1c levels. All future measurements will be compared against the baseline measures established when participants meet criteria for inclusion in the program. Program participants' future measurements will be compared against the baseline measures established in DY3 and DY4.

Demonstration Years 4 and 5 will focus on achieving lower depression inventory scores on the PHQ-9. Through participation in the intervention, program participants will receive treatment for their depression. The undiagnosed and untreated presence of depression increases the risk of developing certain chronic physical conditions and exacerbates the outcome and prognosis of many chronic physical health conditions. Integrating behavioral health treatment with chronic physical health concerns (diabetes) is expected to improve patient outcomes.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The Category 2 project develops a care management intervention for a specific population of people with co-occurring clinical depression and diabetes. The care management intervention focuses on depression management which when properly managed helps patients to focus on self-care skills to properly manage the chronic physical disease. The goal of the intervention is to improve overall health outcomes. The clinical care team will help the participant to manage his or her diseases, teach self-care skills to control the diseases, and the care team will continuously monitor the diseases. These interventions are expected to positively impact a proportion of participants who as a result will achieve lowered depression inventory scores.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.17	*3.IT-1.9*	*Depression management: Depression Remission at Twelve Months (NQF# 0710)*	
Performing Provider: *Community Care Collaborative*			307459301
Related Category 1 or 2 Projects:	307459301.2.3 Integrated Behavioral Health Intervention for Chronic Disease Management		
Starting Point/Baseline:	0 (new program)		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning - Develop and implement a plan for gathering and analyzing individual patient data (PHQ-9 scores, demographic data, etc.) to aid in program assessment and changes in patient health across demonstration years Data Source: Assessment of best practice for gathering individual patient over time for analysis Process Milestone 1 Estimated Incentive Payment: $ 256,512	**Process Milestone 2 [P-2] Establish baseline rate on clinical measures** Data Source: Patient medical records Target: Establish baseline clinical measures on patients Process Milestone 2 Estimated Incentive Payment (maximum amount): $ 361,017	**Outcome Improvement Target 1 [IT-1.9] – Depression Management: Depression Remission at Twelve Months (NQF#0710)** Numerator: Adults 18 years and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five. Denominator: Adult age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine. Data Source: Patient records. Target: 15% remission rate for participants Outcome Improvement Milestone 1	**Outcome Improvement Target 2 [IT-1.9] – Depression Management: Depression Remission at Twelve Months (NQF#0710)** Numerator: Adults 18 years and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five. Denominator: Adult age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine. Data Source: Patient records. Target: 30% remission rate for participants Outcome Improvement Milestone 2

307459301.3.17	*3.IT-1.9*	*Depression management: Depression Remission at Twelve Months (NQF# 0710)*	
Performing Provider: *Community Care Collaborative*			307459301
Related Category 1 or 2 Projects:	307459301.2.3 Integrated Behavioral Health Intervention for Chronic Disease Management		
Starting Point/Baseline:	0 (new program)		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
		Estimated Incentive Payment (maximum amount): $475,022	Estimated Incentive Payment (maximum amount): $798,038
Year 2 Estimated Outcome Amount: $ 256,512	Year 3 Estimated Outcome Amount: $ 361,017	Year 4 Estimated Outcome Amount: $ 475,022	Year 5 Estimated Outcome Amount: $798,038
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 1,890,589			

Title of Outcome Measure (Improvement Target): OD – 1 Primary Care and Chronic Disease Management

IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059

Unique RHP Outcome Identification Number: 307459301.3.18 Pass 3

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description

The outcome improvement target is [IT-1.11]: Diabetes care: BP control (<140/90mm Hg) – NQF 0061.

Process Milestones for Each Year

DY2 - P-1 – Project planning – Identify program participant size, develop project timeline, etc.

DY3 - P-2 – Establish baseline – establish baseline rates for clinical measurements for program participants

Outcome Improvement Targets for Each Year:

DY 4: [IT-1.11]: 10% drop in the number of patients who maintain HbA1c poor control (>9.0%)

DY 5: [IT-1.11]: 20% drop in the number of patients who maintain HbA1c poor control (>9.0%)

Related Category 1 and Category 2 Unique RHP Project Identifiers

307459301.2.3

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

In Demonstration years 2 and 3, this project will engage in process milestones that prepare for program implementation. In DY2, the process milestone is to engage in project planning. The planning year is needed to develop best practices by examining and evaluating practices the literature and from the existing provider network, and developing a practice protocol. The project planning year also will be used to determine the ideal clinic sites that are best suited to carry out the program, and identify the number of additional staff to hire.

Demonstration Year 3 focuses on establishing baseline data. Baseline data will be established on program participants depression inventory (PHQ-9) and hemoglobin A1c (HbA1c) levels. Program participants' future measurements will be compared against the baseline measures established in DY3 and DY4.

By Demonstrations Years 4 and 5, the diabetes control outcome of reducing the number of patients with poor HbA1c poor control is expected. Through participation in the intervention, program participants will receive treatment for their depression which also will have the effect of helping patients better manage their chronic disease condition. Integrating behavioral health treatment with chronic physical health concerns (diabetes) is expected to improve patient outcomes. Diabetes is one of the most costly and highly prevalent chronic diseases in the United States, and leads to many complications. Managing hemoglobin A1c is an important measure of diabetes management.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Baseline will be established in DY3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The Category 2 project develops a care management intervention for a specific population of people with clinical depression and diabetes. This care management intervention focuses on depression management which when properly managed helps patients to focus on self-care skills to properly manage their chronic physical disease. The goal of the intervention is to improve overall health outcomes. The clinical care team will help the participant to manage his or her diseases, teach self-care skills to control the diseases, and the care team will continuously monitor the diseases. These interventions are expected to positively impact a proportion of participants who as a result will achieve lowered depression inventory scores.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.18	*3.IT-1.10*	**Diabetes Care: HbA1c poor control (>9.0%) – HQF 0059**	
Performing Provider: Community Care Collaborative			307459301
Related Category 1 or 2 Projects:	307459301.2.3 Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients		
Starting Point/Baseline:	0 (new program)		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning - Develop and implement a plan for gathering and analyzing individual patient data (HbA1C scores, demographic data, etc.) to aid in program assessment and changes in patient health across demonstration years Data Source: Assessment of best practice for gathering individual patient over time for analysis Process Milestone 1 Estimated Incentive Payment: $ 256,512	**Process Milestone 2 [P-2] Establish baseline rate on clinical measures** Data Source: EHR Target: Establish baseline data on all participants Process Milestone 2 Estimated Incentive Payment (maximum amount): $ 361,017	**Outcome Improvement Target 1 [IT-1.10]: Diabetes Care: HbA1c poor control (>9.0%) – HQF 0059** Data Source: EHR Target: 10% reduction in the number of patients demonstrating poor HbA1C control (>9.0%). Outcome Improvement Target 1 Estimated Incentive Payment (maximum amount): $ 475,022	**Outcome Improvement Target 2 [IT-1.10]: Diabetes Care: HbA1c poor control (>9.0%) – HQF 0059** Data Source: EHR Target: 20% reduction in the number of patients from cohorts enrolled in DY3 and DY4 (Total N = 1000) demonstrating poor HbA1C control (>9.0%). Outcome Improvement Target 2 Estimated Incentive Payment (maximum amount): $ 798,038
Year 2 Estimated Outcome Amount: $ 256,512	Year 3 Estimated Outcome Amount: $ 361,017	Year 4 Estimated Outcome Amount: $ 475,022	Year 5 Estimated Outcome Amount: $ 798,038
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,890,589			

Title of Outcome Measure (Improvement Target): IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea*
Unique RHP outcome identification number(s): 307459301.3.19

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description: IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea*
This outcome measure will track and report on utilization rates for two target populations:

- African American clients <25 years receiving services at clinics participating in this intervention
- Hispanic clients <25 years receiving services at clinics participating in this intervention

For each target population, the improvement target will use the following methodology:

- Numerator: Utilization rates of clinical preventative services (testing, preventative services, treatment) for Gonorrhea for African American/Hispanic clients <25 years receiving services at clinics participating in this intervention
- Denominator: Total Number of African American/Hispanic clients <25 years receiving services at clinics participating in this intervention

Process Milestones for Each Year:

DY 2: P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3: P-3: Develop and test data systems to track utilization rates of clinical preventative services for African American/Hispanic clients <25 years receiving services at clinics participating in this intervention
P-2: Establish baseline utilization rates for African American/Hispanic clients <25 years
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-11.3: TBD % increase in utilization rate
DY 5: IT-11.3: TBD % increase in utilization rate

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.2.4

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Available data from Austin Travis County Health and Human Services Department (ATCHHSD), the local public health department, demonstrate disparities for rates of STD infection among minority populations. Over the past decade, African Americans consistently have shown the highest rate of Gonorrhea, more than twice the rate of Whites or Hispanics. This improvement target will track utilization rates of clinical preventative services for African Americans and Hispanic clients <25 years receiving services at clinics participating in this intervention.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

DY2 and DY3 will be devoted to project planning, identifying needed resources, and developing and testing data systems in order to track utilization rates for African American and Hispanic clients <25 years. Data systems will build on existing EHR and HIE capabilities. During DY3, baseline rates will be established for African American and Hispanic clients <25 years receiving services at clinics participating in this intervention. Using this baseline, outcome improvement targets will be refined for DY4 and DY5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Expanded access to STD screening and treatment services will ensure that more patients receive the right care at the right time in the right setting before STD transmission or adverse health effects from untreated STD occurs. The related Category 2 project will provide easy access to testing and treatment through walk-in hours 6 days per week.

Bilingual health educators will work with multiple partner agencies such as community colleges, substance abuse treatment centers, nonprofits, and school districts to provide STD health education and referral information. Additionally, health educators will be deployed for specific target populations, including African Americans, who consistently demonstrate the highest rates for STD infections. As a result, this project expects an increase in utilization rates of clinical preventive services for Gonorrhea among African Americans and Hispanic clients <25 years.

Outcome Measure Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative (CCC) considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.19	*IT-11.3*	**Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea***	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.4 – Sexually Transmitted Disease Screening, Treatment, and Prevention*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project plans detailing needed resources and proposed implementation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $69,987	**Process Milestone 2** [P-3]: Develop and test data systems to track utilization rates of clinical preventative services for Gonorrhea for **African American** and **Hispanic** clients <25 years receiving services at clinics participating in this intervention Data Source: EHR/HIE Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $32,913 **Process Milestone 3** [P-2]**:** Establish baseline utilization rate for **African American** clients <25 years Data Source: EHR/HIE Process Milestone 3 Estimated Incentive Payment: $32,914 **Process Milestone 4** [P-2]**:** Establish baseline utilization rate for **Hispanic** clients <25 years	**Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea* Improvement Target: Increase utilization rate for **African American** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $66,019 **Outcome Improvement Target 2** [IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *Gonorrhea* Improvement Target: Increase utilization rate for **Hispanic** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE	**Outcome Improvement Target 2** IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea* Improvement Target: Increase utilization rate for African American clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $114,815 **Outcome Improvement Target 4** [IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *Gonorrhea* Improvement Target: Increase utilization rate for **Hispanic** clients <25 years by TBD% compared to baseline.

307459301.3.19	*IT-11.3*	**Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Gonorrhea***	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.4 – Sexually Transmitted Disease Screening, Treatment, and Prevention*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: EHR/HIE Process Milestone 4 Estimated Incentive Payment: $32,914	Outcome Improvement Target 2 Estimated Incentive Payment*:* $66,018	Data Source: EHR/HIE Outcome Improvement Target 4 Estimated Incentive Payment*:* $114,814
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 69,987	Year 3 Estimated Outcome Amount: $ 98,741	Year 4 Estimated Outcome Amount: $132,037	Year 5 Estimated Outcome Amount: $229,629
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$ 530,394**			

Title of Outcome Measure (Improvement Target): IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia*
Unique RHP outcome identification number(s): 307459301.3.20

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description: IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia*
This outcome measure will track and report on utilization rates for two target populations:

- African American clients <25 years receiving services at clinics participating in this intervention
- African American clients <25 years receiving services at clinics participating in this intervention

For each target population, the improvement target will use the following methodology:

- Numerator: Utilization rates of clinical preventative services (testing, preventative services, treatment) for Chlamydia for African American /Hispanic clients <25 years receiving services at clinics participating in this intervention
- Denominator: Total Number of African American /Hispanic clients <25 years receiving services at clinics participating in this intervention

Process Milestones for Each Year:

DY 2: P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3: P-3: Develop and test data systems to track utilization rates of clinical preventative services for African American /Hispanic clients <25 years receiving services at clinics participating in this intervention
P-2: Establish baseline utilization rates for African American /Hispanic clients <25 years
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-11.3: TBD % increase in utilization rate for African American /Hispanic clients <25 years
DY 5: IT-11.3: TBD % increase in utilization rate for African American/Hispanic clients <25 years

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.2.4

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Available data from Austin Travis County Health and Human Services Department (ATCHHSD), the local public health department, demonstrate disparities for rates of STD infection among minority populations. Over the past decade, African Americans and Hispanics consistently have shown the highest rates of Chlamydia.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

DY2 and DY3 will be devoted to project planning, identifying needed resources, and developing and testing data systems in order to track utilization rates for African American and Hispanic clients <25 years. Data systems will build on existing EHR and HIE capabilities. During DY3, baseline rates will be established for African American and Hispanic clients <25 years receiving services at clinics participating in this intervention. Using this baseline, outcome improvement targets will be refined for DY4 and DY5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Expanded access to STD screening and treatment services will ensure that more patients receive the right care at the right time in the right setting before STD transmission or adverse health effects from untreated STD occurs. The related Category 2 project will provide easy access to testing and treatment through walk-in hours 6 days per week.

Bilingual health educators will work with multiple partner agencies such as community colleges, substance abuse treatment centers, nonprofits, and school districts to provide STD health education and referral information. Additionally, health educators will be deployed for specific target populations, including African Americans and Hispanics, who consistently demonstrate the highest rates for STD infections. As a result, this project expects an increase in utilization rates of clinical preventive services for Chlamydia among African Americans and Hispanic clients <25 years.

Outcome Measure Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative (CCC) considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.20	*IT-11.3*	**Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia***	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.4 – Sexually Transmitted Disease Screening, Treatment, and Prevention*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project plans detailing needed resources and proposed implementation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $69,988	**Process Milestone 2** [P-3]: Develop and test data systems to track utilization rates of clinical preventative services for Chlamydia for **African American** and **Hispanic** clients <25 years receiving services at clinics participating in this intervention Data Source: EHR/HIE Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $32,914 **Process Milestone 3** [P-2]**:** Establish baseline utilization rate for **African American** clients <25 years Data Source: EHR/HIE Process Milestone 3 Estimated Incentive Payment: $32,913	**Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia* Improvement Target: Increase utilization rate for **African American** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 66,019 **Outcome Improvement Target 2** [IT-11.3]: Increase utilization rate for **Hispanic** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 66,019	**Outcome Improvement Target 3** IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia* Improvement Target: Increase utilization rate for **African American** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 4 Estimated Incentive Payment*:* $ 114,815 **Outcome Improvement Target 4** IT-11.3]: Increase utilization rate for **Hispanic** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 4 Estimated Incentive Payment*:* $ 114,815

307459301.3.20	*IT-11.3*	**Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *Chlamydia***	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.4 – Sexually Transmitted Disease Screening, Treatment, and Prevention*		
Starting Point/Baseline:	*To be developed 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 4 [P-2]**:** Establish baseline utilization rate for **Hispanic** clients <25 years Data Source: EHR/HIE Process Milestone 4 Estimated Incentive Payment: $32,913		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $69,988	Year 3 Estimated Outcome Amount: $ 98,740	Year 4 Estimated Outcome Amount: $132,038	Year 5 Estimated Outcome Amount: $229,630
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $ 530,396**			

Title of Outcome Measure (Improvement Target): IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *HIV*
Unique RHP outcome identification number(s): 307459301.3.21

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description: IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – *HIV*

- Numerator: Utilization rates of clinical preventative services (testing, preventative services, referral for treatment) for HIV for African American clients <25 years receiving services at clinics participating in this intervention
- Denominator: Total Number of African American clients <25 years receiving services at clinics participating in this intervention

Process Milestones for Each Year:

DY 2: P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3: P-3: Develop and test data systems to track utilization rates of clinical preventative services for African American clients <25 years receiving services at clinics participating in this intervention
P-2: Establish baseline utilization rates for African American clients <25 years
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-11.3: TBD % increase in utilization rate
DY 5: IT-11.3: TBD % increase in utilization rate

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.2.4

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Available data from Austin Travis County Health and Human Services Department (ATCHHSD), the local public health department, demonstrate disparities for rates of HIV infection among minority

populations. Over the past decade, African Americans consistently have shown the highest rate of HIV. In 2010, the HIV rate among African Americans was more than three times the rate of Whites or Hispanics. This improvement target will track utilization rates of clinical preventative services for African American clients <25 years receiving services at clinics participating in this intervention.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

DY2 and DY3 will be devoted to project planning, identifying needed resources, and developing and testing data systems in order to track utilization rates for African American clients <25 years. Data systems will build on existing EHR and HIE capabilities. During DY3, baseline rates will be established for African American clients <25 years receiving services at clinics participating in this intervention. Using this baseline, outcome improvement targets will be refined for DY4 and DY5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Expanded access to HIV screening and treatment services will ensure that more patients receive the right care at the right time in the right setting before HIV transmission or adverse health effects from untreated HIV occurs. The related Category 2 project will provide easy access to testing and treatment through walk-in hours 6 days per week.

Bilingual health educators will work with multiple partner agencies such as community colleges, substance abuse treatment centers, nonprofits, and school districts to provide HIV health education and referral information. Additionally, health educators will be deployed for specific target populations, including African Americans, who consistently demonstrate the highest rates for HIV infections. As a result, this project expects an increase in utilization rates for HIV testing and clinical preventative services among African American clients <25 years. Clients who have tested positive for HIV will be referred out for treatment.

Outcome Measure Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative (CCC) considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.21	*IT-11.3*	**Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *HIV***	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.4 – Sexually Transmitted Disease Screening, Treatment, and Prevention*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project plans detailing needed resources and proposed implementation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $34,993	**Process Milestone 2** [P-3]: Develop and test data systems to track utilization rates of clinical preventative services for HIV for **African American** clients <25 years receiving services at clinics participating in this intervention Data Source: EHR/HIE Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $24,686 **Process Milestone 3** [P-2]**:** Establish baseline utilization rate for **African American** clients <25 years Data Source: EHR/HIE Process Milestone 3 Estimated Incentive Payment: $24,685	**Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *HIV* Improvement Target: Increase utilization rate for **African American** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $66,018	**Outcome Improvement Target 2** IT-11.3]: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – *HIV* Improvement Target: Increase utilization rate for **African American** clients <25 years by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $114,815
Year 2 Estimated Outcome Amount: $ 34,993	Year 3 Estimated Outcome Amount: $ 49,371	Year 4 Estimated Outcome Amount: $66,018	Year 5 Estimated Outcome Amount: $114,815
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $ 265,197**			

Title of Outcome Measure (Improvement Target): IT-1.20 Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies

Unique RHP outcome identification number(s): 307459301.3.22 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Outcome Measure Description

Overall Outcome Measure Description: IT-1.20 Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies

This is a custom improvement target, using the following methodology:

- Numerator: Number of Pregnancies Among Females <25 years receiving services at clinics participating in this intervention
- Denominator: Total Number of Females <25 years receiving services at clinics participating in this intervention

Process Milestones for Each Year:

DY 2: P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 3: P-3: Develop and test data systems to track pregnancy rates among females <25 years receiving services at clinics participating in this intervention
P-2: Establish baseline pregnancy rate among females <25 years receiving services at clinics participating in this intervention
DY 4: N/A
DY 5: N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: N/A
DY 4: IT-1.20: TBD % decrease in pregnancy rate
DY 5: IT-1.20: TBD % decrease in pregnancy rate

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.2.5

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Preventing unintended pregnancies among adolescents and young adults is a goal under Healthy People 2020 and a priority for the Centers for Disease Control. IT-1.20 was selected because reducing

unintended pregnancies reduces public health costs and improves health outcomes. According to the CDC, births resulting from unintended pregnancies result in negative public health outcomes including delays in initiation of prenatal care, preterm birth and low birth weight.

DY2 and DY3 will be devoted to project planning, identifying needed resources, and developing and testing data systems in order to track pregnancy rates. Data systems will build on existing EHR and HIE capabilities. During DY3, baseline rates will be established for females <25 years receiving services at clinics participating in this intervention. By expanding access to LARCs through the related Category 2 project, this project aims to decrease pregnancy rates for the targeted population in DY4 and DY5.

If applicable, indicate that outcome improvement targets will be determined in DY 2 or 3.

Baseline pregnancy rates among females <25 years will be established during DY3. Using this baseline, outcome improvement targets will be refined for DY4 and DY5.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

Per American College of Obstetricians and Gynecologists (ACOG) clinician guidelines, long-acting reversible contraception (LARCs) are recommended for women at high risk for unintended pregnancy due to high effectiveness rate in reducing unintended pregnancy, high continuation rate among use women and medical appropriateness for young women, including nulliparous and parous women.

For uninsured and low-income women, LARCs are a preferred and appropriate strategy for preventing unintended pregnancies and supporting healthy birth spacing yet are out of reach to due to the cost. The related Category 2 project addresses this challenge by providing LARCs, including IUDs and implants, to uninsured and Medicaid eligible women at risk for unintended pregnancies and accompanying negative health outcomes. By expanding access to LARCs, this project expects to decrease pregnancy rates among the target population.

Outcome Measure Valuation

Approach and Rationale/Justification for Valuing Project

In valuing its projects, the Community Care Collaborative (CCC) considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.22	*IT-1.20*	**Reduction of Pregnancy Rates Among Females at Risk for Unintended Pregnancies**	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.5 – Adolescent and Young Adult Pregnancy Prevention*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project plans detailing needed resources and proposed implementation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $242,471	**Process Milestone 2** [P-3]: Develop and test data systems to track pregnancy rates among females <25 years receiving services at clinics participating in this intervention Data Source: EHR/HIE Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $171,044 **Process Milestone 3** [P-2]**:** Establish baseline pregnancy rate among females <25 years receiving services at clinics participating in this intervention. Data Source: EHR/HIE Process Milestone 3 Estimated Incentive Payment: $171,044	**Outcome Improvement Target 1** [IT-1.20]: Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies Improvement Target: Decrease pregnancy rate by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $457,444	**Outcome Improvement Target 2** [IT-1.20]: Other Outcome Improvement Target: Reduction of Pregnancy Rate Among Females at Risk for Unintended Pregnancies Improvement Target: Decrease pregnancy rate by TBD% compared to baseline. Data Source: EHR/HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $795,554
Year 2 Estimated Outcome Amount:: $ 242,471	Year 3 Estimated Outcome Amount: $ 342,088	Year 4 Estimated Outcome Amount: $ 457,444	Year 5 Estimated Outcome Amount: $795,554
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $ 1,837,557**			

Title of Outcome Measure (Improvement Target): **IT-9.2:ED Appropriate Utilization**

Unique RHP Outcome Identification Number: **307459301.3.23 Pass 3**

Performing Provider Name: **Community Care Collaborative**

Performing Provider TPI: **307459301**

Outcome Measure Description

Overall Outcome Measure Description

IT-9.2 ED Appropriate Utilization

- Reduce all ED visits (including ACSC)
- Reduce ED visits for target conditions
  - Congestive heart failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease/Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disorder
  - Asthma

Process Milestones for Each Year

DY 2: *P-1 Project Planning* – Development of a data sharing plan to ensure program can adequately track ED utilization of program participants.

DY 3: P-3 Develop and test data systems
P-2 Establish baseline rates
P-7 Establish improvement targets

DY 4: *N/A*

DY 5: *N/A*

Outcome Improvement Targets for Each Year:

DY 2: *N/A*

DY 3: *N/A*

DY 4: Reduce ED visits for target conditions by TBD %

DY 5: Reduce ED visits for target conditions by TBD %

Related Category 1 and Category 2 Unique RHP Project Identifiers: 307459301.2.6

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Active case management by patient navigators has been shown to reduce EMS utilization and resulting ED visits. For current program participants, the intervention has reduced utilization of emergency medical transport services by 62%. The expanded program will provide an in-home assessment of patients with chronic conditions that frequently utilize the ED to try to establish the cause of frequent use and navigate to appropriate services in the appropriate setting. For this reason, ED utilization was chosen as an outcome improvement target.

In DY 2, data sharing protocols between the CCC, ATCEMS and hospital emergency departments must be developed so the CCC and ATCEMS can capture and monitor ED utilization among navigation program participants and CCC patients as a whole.

In DY 3, the program will establish a baseline to measure the rate of ED utilization. An improvement target over this baseline will also be determined for DY 4 and 5 during DY 3.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

The related Category 2 project expands the Community Paramedic Patient Navigation Program to assess patients who frequently utilize EMS services and also to provide patient navigation services to CCC patients who have multiple chronic conditions. Active case management by patient navigators has been shown to reduce EMS utilization and resulting ED visits. For current program participants, the intervention has shown to reduce EMS utilization by 62%.

Outcome Measure Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.

307459301.3.23	*IT-9.2*	*ED Appropriate Utilization*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.6 - Community Health Paramedic Navigation Program*		
Starting Point/Baseline:	*To be developed in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning Data Source: Development of a data sharing plan to ensure program can adequately track ED utilization of program participants. Process Milestone 1 Estimated Incentive Payment: $347,013	**Process Milestone 2** [P-3]: Develop and test data systems. Data Source: Functioning data system that implements plan developed in DY 2. Process Milestone 1 Estimated Incentive Payment: $163,193 **Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Clinical utilization data Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $163,193	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Improvement Target: TBD Data Source: Clinical utilization data Outcome Improvement Target 1 Estimated Incentive Payment*:* $654,671	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Improvement Target: TBD Data Source: Clinical utilization data Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,138,559

307459301.3.23	*IT-9.2*	*ED Appropriate Utilization*	
Community Care Collaborative			*307459301*
Related Category 1 or 2 Projects:	*307459301.2.6 - Community Health Paramedic Navigation Program*		
Starting Point/Baseline:	*To be developed in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Process Milestone 3 [P-7] Establish improvement targets Data Source: Documentation of improvement target determination Process Milestone 3 Estimated Incentive Payment: $163,193		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $347,013	Year 3 Estimated Outcome Amount: $489,580	Year 4 Estimated Outcome Amount: $654,671	Year 5 Estimated Outcome Amount: $1,138,559
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,629,823			

Dell Children's Medical Center (DCMC)
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): IT-1.20 Other Outcome Improvement Target

Unique RHP Outcome Identification Number: 186599001.3.1 Pass 1

Outcome Measure Description:

IT-1.20 Other Outcome Improvement Target
The percent of patient visits for patients aged 6 through 17 with a diagnosis of major depressive disorder with an assessment for suicide risk. 2010 Sep. NQMC:004438[152]

- Numerator – The number of patient visits with an assessment for suicide risk.
- Denominator – The number of patient visits with a diagnosis of major depressive disorder (aged 6 through 17 years).

Process Milestones:

DY2 [P-3] Develop and test systems to support Outcome Improvement Target

DY3 [P-2] Establish baseline rates

Outcome Improvement Targets for each year:

DY4 [IT-1.20] Increase by 3% over baseline the number of patient visits for program participants aged 6 through 17 years of age with a diagnosis of major depressive disorder with an assessment for suicide risk.

DY5 [IT-1.20] Increase by 5% over baseline the number of patient visits for program participants aged 6 through 17 years of age with a diagnosis of major depressive disorder with an assessment for suicide risk.

Rationale:

This evidence-based measure was selected because Central Texas has been flagged and monitored by the CDC for the past several years as a Suicide Cluster for adolescents given the high rate of adolescent suicide. Although psychotherapy is recommended for children and adolescents with a diagnosis of major depressive disorder, research has indicated that it is currently underutilized and declining in use. In 2001-2002, approximately 68% of children and adolescents being treated for major depressive disorder received psychotherapy or mental health counseling, a 15% decrease from 6 years earlier.[153]

Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment an important aspect of care that should be assessed at each visit. Suicidal

[152]Physician Consortium for Performance Improvement®. Child and adolescent major depressive disorder physician performance measurement set. Chicago (IL): American Medical Association (AMA); 2010 Sep. 30 p. [13 references]

[153] Ma J, Lee KV, Stafford RS. Depression treatment during outpatient visits by U.S. children and adolescents. J Adolsce Health. 2005 Dec; 37 (6): 434-42.

behavior exists along a continuum from passive thoughts of death to a clearly developed plan and intent to carry out that plan. Because depression is closely associated with suicidal thoughts and behavior, it is imperative to evaluate these symptoms at the initial and subsequent assessments. Also, it is crucial to evaluate the risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that might influence the desire to attempt suicide. The risk for suicidal behavior increases if there is a history of suicide attempts, comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse), impulsivity and aggression, availability of lethal agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence), and a family history of suicidal behavior. (AACAP, 2007)

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol

This project is to make a significant impact on the well-being of students enrolled in the program as well as their family and community at-large. This project is also expected to address behavioral healthcare needs prior to disruptive and deleterious events such as criminal justice system involvement. Additionally, when the program was piloted, school attendance increased by 4% for students enrolled in the pilot and behavioral offenses resulting in a disciplinary referral decrease.

Unique Cat 3 ID: 186599001.3.1	*Ref. Number from RHP PP* IT-1.20	**Other Outcome Improvement Target**	
Performing Provider: Dell Children's Medical Center			**TPI:** 186599001
Related Category 1 or 2 Projects::	*Unique Category 1 Identifier* - 186599001.1.1		
Starting Point/Baseline:	To be developed 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-3]: Develop and test data systems. Data Source: Business Intelligence Process Milestone 2 Estimated Incentive Payment: $44,781	**Process Milestone 2** [P-3]: Target Establish baseline rates .Data Source: Business Intelligence Process Milestone 4 Estimated Incentive Payment: $89,562	**Outcome Improvement Target 1** [IT-1.20]: Quality of Life Improvement Target: Increase by 3% over baseline the percentage of patient visits for program participants aged 6 through 17 years of age with a diagnosis of major depressive disorder with an assessment for suicide risk Outcome Improvement Target 1 Estimated Incentive Payment: $134,342	**Outcome Improvement Target 2** [IT-1.20]: Quality of Life Improvement Target: Increase by 5% over baseline the percentage of patient visits for program participants aged 6 through 17 years of age with a diagnosis of major depressive disorder with an assessment for suicide risk Outcome Improvement Target 2 Estimated Incentive Payment: $295,553
Year 2 Estimated Outcome Amount: $44,781	**Year 3 Estimated Outcome Amount: $89,562**	**Year 4 Estimated Outcome Amount: $134,342**	**Year 5 Estimated Outcome Amount: $295,553**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $564,238			

Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Improvement Target: Zone Body Mass Index (zBMI)

Unique RHP Outcome Identification Number: 186599001.3.2 Pass 1

Performing Provider: UMCB; TPI 137265806

Outcome Measure Description:

OD-9, Right Care, Right Setting
IT-9.4 Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (NQF #0024)[154]

Percentage of children 2-8 years of age who had an outpatient visits at the clinic and who had evidence of body mass index (CMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Numerator: Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Denominator: Children 3-17 years of age with at least one outpatient visit with a physician or allied healthcare worker.

Exclusion: children who have a diagnosis of pregnancy during measurement year.

Data source:

1. *BMI Percentile: BMI percentile during the measurement year:* documentation must include height, weight and BMI percentile during the measurement year. Either of the following meets criteria for BMI percentile.
   - BMI percentile, or
   - BMI percentile plotted on age-growth chart

   For members who are younger than 16 years of age on the date of service, only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. A BMI value is not acceptable for this age range.

   For adolescents 16–17 years on the date of service, documentation of a BMI value expressed as kg/m2 is acceptable.

2. *Counseling for Nutrition: Documentation of counseling for nutrition or referral for nutrition education during the measurement year*: documentation must include a note indicating the date and at least one of the following.

[154] National Committee for Quality Assurance (NCQA). HEDIS 2012: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2011

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
- Checklist indicating nutrition was addressed
- Counseling or referral for nutrition education
- Member received educational materials on nutrition
- Anticipatory guidance for nutrition

3. Counseling for Physical Activity: Documentation of counseling for physical activity or referral for physical activity during the measurement year: documentation must include a note indicating the date and at least one of the following.

    - Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
    - Checklist indicating physical activity was addressed
    - Counseling or referral for physical activity
    - Member received educational materials on physical activity
    - Anticipatory guidance for physical activity

Process Milestones:

- DY2:
    - [P-3] Test data systems to support Outcome Improvement Target
- DY3
    - [P-2] Establish baseline rate for Outcome

Outcome Improvement Targets for each year:

- DY4 [IT-12.6]: Increase by 3% over baseline the percentage of program participants (children age 2-18) who had an who had evidence of body mass (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
- DY5 [IT-12.6]: Increase by 5% over baseline the percentage of program participants (children age 2-18) who had an who had evidence of body mass (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Rationale:
This evidenced-based measure was selected because it is aligned to program goals and outcomes and will measure the project's effectiveness for participants. Our multi-disciplinary innovations in the area of patient and family education, health promotion resources, support programs, along with clinical interventions will include services measured by this outcome.
Body mass index (BMI) is a useful tool for assessing and tracking the degree of obesity among adolescents. Screening for overweight or obesity begins in the provider's office with the calculation of BMI. Providers can estimate a child's BMI percentile for age and gender by plotting the calculated value of BMI with growth curves published and distributed by CDC. Medical evaluations should

include investigation into possible endogenous causes of obesity that may be amenable to treatment, and identification of any obesity-related health complications.

Because BMI norms for youth vary with age and gender, BMI percentiles rather than absolute BMI must be determined. The cut-off values to define the heaviest children are the 85th and 95th percentiles. In adolescence, as maturity is approached, the 85th percentile roughly approximates a BMI of 25, which is the cut-off for overweight in adults. The 95th percentile roughly approximates a BMI of 30 in the adolescent near maturity, which is the cut-off for obesity in adults. The cut-off recommended by an expert committee to define overweight (BMI greater than or equal to 95th percentile) is a conservative choice designed to minimize the risk of misclassifying non-obese children.

About two-thirds of young people in grades 9–12 do not engage in recommended levels of physical activity. Daily participation in high school physical education classes dropped from 42 percent in 1991 to 33 percent in 2005. In the past 30 years, the prevalence of overweight and obesity has increased sharply for children. Among young people, the prevalence of overweight increased from 5.0 percent to 13.9 percent for those aged 2–5 years; from 6.5 percent to 18.8 percent for those aged 6–11 years; and from 5.0 percent to 17.4 percent for those aged 12–19 years. In 2000 the estimated total cost of obesity in the U.S. was about $11.7 billion. Promoting regular exercise activity and healthy eating, as well as creating an environment that supports these behaviors, is essential to addressing the problem.[155]

Outcome Measure Valuation:

- [155] Baker S, Barlow S, Cochran W, Fuchs G, Klish W, Krebs N, Strauss R, Tershakovec A, Udall J. Overweight children and adolescents: a clinical report of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. J Pediatr Gastroenterol Nutr 2005 May;40(5):533-43. [107 references] PubMedCenters for Disease Control and Prevention (CDC). Physical activity and good nutrition: essential elements to prevent chronic diseases and obesity. Atlanta (GA): National Center for Chronic Disease Prevention and Health Promotion; 2007 Apr.

- Dorsey KB, Wells C, Krumholz HM, Concato J. Diagnosis, evaluation, and treatment of childhood obesity in pediatric practice. Arch Pediatr Adolesc Med 2005 Jul;159(7):632-8. PubMed

- Freedman DS, Khan LK, Dietz WH, Srinivasan SR, Berenson GS. Relationship of childhood obesity to coronary heart disease risk factors in adulthood: the Bogalusa Heart Study. Pediatrics 2001 Sep;108(3):712-8. PubMed

Inge TH, Krebs NF, Garcia VF, Skelton JA, Guice KS, Strauss RS, Albanese CT, Brandt ML, Hammer LD, Harmon CM, Kane TD, Klish WJ, Oldham KT, Rudolph CD, Helmrath MA, Donovan E, Daniels SR. Bariatric surgery for severely overweight adolescents: concerns and recommendations. Pediatrics 2004 Jul;114(1):217-23. [46 references] PubMed/Inge TH, Krebs NF, Garcia VF, Skelton JA, Guice KS, Strauss RS, Albanese CT, Brandt ML, Hammer LD, Harmon CM, Kane TD, Klish WJ, Oldham KT, Rudolph CD, Helmrath MA, Donovan E, Daniels SR. Bariatric surgery for severely overweight adolescents: concerns and recommendations. Pediatrics 2004 Jul;114(1):217-23. [46 references] PubMed National Committee for Quality Assurance (NCQA). HEDIS 2012: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2011. various pWhitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. N Engl J Med 1997 Sep 25;337(13):869-73. PubMed

The Multi-Level Family and Child Obesity Initiative is a far-reaching and ambitious project that will impact patients, families and the community. It is expected to reduce the cost of preventable hospital admissions, readmissions and emergency room visits, save lives and keep families healthy. Expansion of services should improve the quality of life for thousands of families and improve their quality of life for many more years to come. Healthy, active students will be able take full advantage of educational opportunities. Entire households will benefit by eating more nutritiously, understanding obesity and its health consequences, and becoming more active and fit individuals. Project valuation will include direct costs, cost avoidance, population impact, quality adjusted life years saved, the overall impact to community, as well as the project's ability to transform healthcare and improving the quality of life for many Austin families.

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CATEGORY 3 ID: 186599001.3.2	*Ref Number from RHP PP: IT-*9.4	Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
Dell Children's Medical Center			*TPI:* 186599001
Related Category 1 or 2 Projects::	*Unique Category 2 Identifier:* 186599001.2.1		
Starting Point/Baseline:	To be developed 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-3]: Develop and test data systems to support Outcome Improvement Target [IT-1.10.1] Data Source: Business Intelligence **Process Milestone 1 Estimated Incentive Payment: $244,670**	**Process Milestone 2** [P-2]: Establish baseline rate Data Source: Patient Records; Business Intelligence **Process Milestone 2 Estimated Incentive Payment: $349,360**	**Outcome Improvement Target 1** Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents [IT-12.6]: Increase by 3% over baseline the percentage of program participants (children age 2-18) who had an who had evidence of body mass (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year. **Data Source:** Participant records **Outcome Improvement Target 1 Estimated Incentive Payment: $522,773**	**Outcome Improvement Target 2** Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents [IT-12.6]: Increase by 5% over baseline the percentage of program participants (children age 2-18) who had an who had evidence of body mass (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year. **Data Source:** Participant records **Outcome Improvement Target 2 Estimated Incentive Payment: $1,152,889**
Year 2 Estimated Outcome Amount: $244,670	Year 3 Estimated Outcome Amount: $349,360	Year 4 Estimated Outcome Amount: $522,773	Year 5 Estimated Outcome Amount: $1,152,889
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,269,692			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-9.2 - Domain (OD-9) Right Care, Right setting**

Unique RHP Outcome Identification Number: **186599001.3.3 Pass 1**

Performing Provider Name: **Dell Children's Medical Center**

Performing Provider TPI: **186599001**

Outcome Measure Description:

IT-9.2 ED appropriate utilization

- Reduce pediatric Emergency Department visits

Process Measures:

- DY2: P-3 – Develop and test data systems to support outcome improvement targets
- DY3: P-2 – Establish baseline rates.

Outcome Improvement Targets for Each Year:

- DY4: [IT-9.2] Reduce the number of pediatric ED visits by program enrollees at provider's hospital system by 20% below baseline to be determined in DY3.
- DY5: [IT-9.2] Reduce the number of pediatric ED visits by program enrollees at provider's hospital system by 30% below baseline to be determined in DY3.

Rationale:

The project relies heavily on literature by AHRQ and the efforts to come up with an initial core set of quality measures in Pediatrics (see http://www.ahrq.gov/chipra/lessons.htm; (http://www.ahrq.gov/chipra/corebackground/corebacktab.htm)

ED visits is one of the core measures of utilization suggested by the AHRQ as part of the CHIPRA (Children's Health Insurance Reauthorization Act) requirements.

For our population of patients, each component of the model – i.e patient empowerment, 24/7 access, same-day appointment for intercurrent illnesses, integrated subspecialist care, evidence-based protocols all contribute to better outcome and an increased number of "well days" for the patient and the family. ED utilization is a good proxy measure for better health and 'increased number of well days'. In addition, it is a measure that allows us to calculate dollars saved by implementing this program.

Interventions that decrease ER visits: In our current model, we provide 24/7 call coverage (by using first line nurse triage service with access to the patients records and care plan). A pediatrician or an advanced practice nurse from the clinic provides back-up. Patient educators ensure that families are well versed on first line problem solving and recognize danger signs that warrant a visit. Sick visits are provided during working hours on weekdays. For very fragile patients where visits are cumbersome, home visits may be made in certain scenarios. This process will ensure that unnecessary visits to the ED are kept to a minimum. In addition, by imbedding key subspecialists

(Rehab medicine, Palliative care and behavioral medicine), the model ensures that the staff gains competency in the principles of each discipline. The core team ensures a high level of adherence to subspecialist recommended regimens by providing the appropriate education and support. This will also decrease the number of ED visits from improper implementation / lack of adherence to treatment regimens.

Outcome Measure Valuation:

Financial value of the reduction in ambulatory sensitive acute care visits. The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The clinic will be collaborating with the Dell Children's Medical Center Analytics department for statistical and analytic support. Data on utilization of ED services by patients enrolled in this project will be extracted from administrative databases on a monthly basis. Analysis on utilization pattern changes, cost savings and return on investment calculations will be provided by the Analytics department.

UNIQUE CATEGORY 3 ID: 186599001.3.3	***Ref Number from RHP PP:*** *IT-9.2*	**ED Appropriate Utilization**	
Performing Provider Name: Dell Children's Medical Center			***TPI*** – 186599001
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 186599001.2.2		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems to support Outcome Improvement Targets Data Source: Business Intelligence/Program Analytics ***Process Milestone 1 Estimated Incentive Payment:*** $374,985	**Process Milestone 2** [P- 2]: Establish baseline rate Outcome Improvement Target 1 Data Source: Patient Records; Program Analytics ***Process Milestone 2 Estimated Incentive Payment***: $448,423	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization – reduce pediatric ED visits Improvement Target: Reduce the number of pediatric ED visits by program enrollees at provider's hospital system by 20% below baseline Data Source: Patient Records, Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $807,766	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization – reduce pediatric ED visits Improvement Target: Reduce the number of pediatric ED visits by program enrollees at provider's hospital system by 30% below baseline Data Source: Patient Records, Program Analytics **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $2,108,140
Year 2 Estimated Milestone Bundle Amount: $374,985	**Year 3 Estimated Milestone Bundle Amount:** $448,423	**Year 3 Estimated Milestone Bundle Amount:** $807,766	**Year 5 Estimated Milestone Bundle Amount**: $2,108,140
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,739,314			

Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Mobile Clinic
Unique RHP Outcome Identification Number: 133340307.3.5 Pass 2
Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**
Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

IT-10.2 Activities of Daily Living – The percentage of individuals receiving Mobile Clinic behavioral health services who show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health
Process Milestones:
Not applicable

Outcome Improvement Targets for each year:
DY2 – Not Applicable
DY3 IT-10.2 10% of individuals receiving Mobile Clinic services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT-10.2 15% of individuals receiving Mobile Clinic services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT-10.2 20% of individuals receiving Mobile Clinic services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.1.1

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Mobile Clinic Services impact an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. By providing mobile clinic services individuals are more likely to seek out needed mental health services since they will be available in their local community. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service

plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

Outcome measures are based on the number of individuals that have begun treatment through the Mobile Clinic and were kept modest due to the interventions requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the percentage of individuals receiving Mobile Clinic services who show improvement on the DLA-20.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 287 individuals receiving mobile clinic services over the life of the project.

133340307.3.5	*3. IT-10.2*	IT-10.2 Activities of Daily Living	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.1.1*		
Starting Point/Baseline:	*Baseline will be individual DLA20 assessment as individuals enter program*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: *Activities of Daily Living* Improvement Target: 10% of individuals receiving Mobile Clinic services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR, assessment tool Outcome Improvement Target 1 Estimated Incentive Payment*:* $112,244	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living Improvement Target: 15% of individuals receiving Mobile Clinic services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/her, assessment tool Outcome Improvement Target 2 Estimated Incentive Payment*:* $179,835	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living Improvement Target: 20% of individuals receiving Mobile Clinic services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/her, assessment tool Outcome Improvement Target 3 Estimated Incentive Payment*:* $260,810
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $112,244	Year 4 Estimated Outcome Amount: $179,835	Year 5 Estimated Outcome Amount: $260,810
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $552,889			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life-SF-12

Unique RHP Outcome Identification Number: 133340307.3.1 Pass 1

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

The SF-12 acquires the individual's overall views about their health, physical and mental, and will be able to demonstrate improvement of individuals receiving both behavioral health and physical health care. In the AIMS Integrated Behavioral Health Care in the Era of the Medical Home study in 2011 the SF-12 showed increased improvement in better physical function as individuals received ongoing integrated care.

Process Milestones for Each Year

N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: At least 5% of consumers in Integrated Care have improved SF-12 measurements
DY 4: At least 10% of consumers in Integrated Care have improved SF-12 measurements
DY 5: At least 15% of consumers in Integrated Care have improved SF-12 measurements

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.1

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Although much of health care is focused on increasing longevity, many of the medical treatments are specifically designed to improve symptoms and function, two essential components of health-related quality of life. In many cases, the best way to measure symptoms and functional status is by direct patient survey. The importance of such patient-reported outcomes is evidenced by their increased use in clinical trials and in drug and device label claims. Effective quality improvement requires relentless focus on the patient outcomes.

The SF-12 acquires the individual's overall views about their health, physical and mental, and will be able to demonstrate improvement of individuals receiving both behavioral health and physical health care. The reason for the improvement targets (DY2 5%, DY3, 10%, and DY4 15%) is based on addressing the physical health issues may include life style changes which will take time for consumers to implement and at times consumers may be reluctant to implement such changes.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

By addressing both an individual's physical health as well as their mental health, the individual should have an overall better quality of life as demonstrated on the SF-12 compared to currently only addressing their behavioral health needs. In the AIMS Integrated Behavioral Health Care in the Era of the Medical Home study in 2011 the SF-12 showed increased improvement in better physical function as individuals received ongoing integrated care

Outcome Measure Valuation

Approach for Valuing Outcome Measure

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The valuation on this project is based on an estimated 200 individuals receiving primary health care over the life of the project.

133340307.3.1	*OD10 IT-10.1*	Quality of Life-SF-12	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.1*		
Starting Point/Baseline:	*Baseline will be individual SF-12 assessments as individuals enter program*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 [IT-10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population Improvement Target: at least 5% of individuals served show improvement in subsequent individual QOL scores Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1Estimated Incentive Payment*:* $86,935	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population Improvement Target: At least 10% of individuals served show improvement in subsequent individual QOL scores Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $139,500	**Outcome Improvement Target 3** [IT-10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population Improvement Target: at least 15% of individuals served show improvement in subsequent individual QOL scores Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $202,174
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $86,935	Year 4 Estimated Outcome Amount: $139,500	Year 5 Estimated Outcome Amount: $202,174
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $428,609			

Title of Outcome Measure (Improvement Target): IT-10.7 Other Outcome Improvement Target: Supports Intensity Scale

Unique RHP Outcome Identification Number: 133340307.3.2 Pass 1

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

The Supports Intensity Scale is a tool designed to measure the intensity of a person with Intellectual and Developmental Disability support needs. It consists of three sections: 1) Support Needs Scale, 2) Supplemental Protection and Advocacy Scale, and 3) Exceptional Medical and Behavioral Support Needs. As a tool, the Supports Intensity Scale is used to measure the frequency and intensity of supports an individual with an intellectual disability needs to meet quality of life goals. Individuals with IDD and mental illness entering the unit should demonstrate improvement during their stay on the overall Supports Intensity Scale (SIS) as improvement is demonstrated on the Exceptional Medical and Behavioral Support Needs. By showing improvement on the SIS, the consumer has shown response to the implemented behavioral supports and is more likely to be successful with a behavioral support plan when returning to their home environment. The Virginia Department of Behavioral Health and Developmental Services has adopted the Supports Intensity Scale as the statewide assessment tool for MR/ID and DS waivers and North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services has prioritized the utilization of the SIS for individuals with high medical and/or behavioral needs..

Process Milestones for Each Year

N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A
DY 3: At least 10% of consumers served by Crisis Center have improved Supports Intensity Scale on subsequent assessment
DY 4: At least 15% of consumers served by Crisis Center have improved Supports Intensity Scale on subsequent assessment
DY 5: At least 20% of consumers served by Crisis Center have improved Supports Intensity Scale on subsequent assessment

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The Supports Intensity Scale (SIS) is a tool designed to measure the intensity of a person with Intellectual and Developmental Disability support needs. It consists of three sections: 1) Support Needs Scale, 2) Supplemental Protection and Advocacy Scale, and 3) Exceptional Medical and Behavioral Support Needs. The SIS measures progress interventions make on enabling the individual to maintain their status living in the community. Individuals with Intellectual and Developmental Disabilities and Mental Illness entering the unit should demonstrate improvement during their stay on the overall Supports Intensity Scale as improvement is demonstrated on the Exceptional Medical and Behavioral Support Needs. The Supports Intensity Scale will be completed upon admission and discharge to monitor progress. The reason for the improvement targets (DY2 10%, DY3, 15%, and DY4 20%) is based on the implementation of behavioral changes takes time for consumers to implement and at times consumers may be reluctant to implement such changes.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

By developing a crisis center to address both the behavioral issues of an individual with IDD and mental illness in the community, the individual will have improved Supports Intensity Scale, maintain their lives in the community setting and avoid institutionalization. Currently, individuals dually diagnosed with IDD and mental health who have a behavioral health crisis are referred to emergency departments or the criminal justice system, by developing a crisis center for this population, individuals can be diverted to the crisis center and avoid unnecessary utilization of emergency departments and the criminal justice system.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided).

133340307.3.2	*OD10 IT-10.7*	Other Outcome Improvement Target: Supports Intensity Scale	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.2*		
Starting Point/Baseline:	*Service not currently available*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.7: Improvement Target: 10% of individuals receiving intervention have improved Supports Intensity Scale Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $57,966	**Outcome Improvement Target 2** IT-10.7: Improvement Target:15% of individuals receiving intervention have improved Supports Intensity Scale Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $93,004	**Outcome Improvement Target 3** IT-10.7: Improvement Target: 20% of individuals receiving intervention have improved Supports Intensity Scale Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $136,387
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $57,966	Year 4 Estimated Outcome Amount: $93,004	Year 5 Estimated Outcome Amount: $136,387
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $287,357			

Title of Outcome Measure (Improvement Target): IT-12.5 Activities of Daily Living/Co-occurring Psychiatric and Substance Use Disorder

Unique RHP outcome Identification number: 133340307.3.3 Pass 1

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

Outcome Measure Description:

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20)Adult Mental Health or Daily Living Activities (DLA-20) Youth Mental Health (Ages 6-18)

Process Milestones: *Not applicable*

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale

DY4 IT10.2 15% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale

DY5 IT10.2 20% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Co-occurring Psychiatric and Substance Use Disorder impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

Outcome measures are based on the number of individuals that have begun treatment in the Co-occurring Psychiatric and Substance Use Disorder program and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years

No baseline is set as the measure is associated with the number of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services who show improvement on the DLA-20 compared to the total number receiving Co-occurring Psychiatric and Substance Use Disorder services in the program

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics

Outcome Measure Valuation

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by 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 area avoided). The valuation on this project is based on 80 consumers over the life of the project.

133340307.3.3	*OD10 IT-10.2*	Activities of Daily Living	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.3*		
Starting Point/Baseline:	*Baseline will be individual DLA20 assessments as individuals enter program*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: *Activities of Daily Living: Demonstrate improvement in ADL scores, as measured by evidence-based and validated assessment tool for the targeted population* Improvement Target: 10% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent individual Activities of Daily Living(DLA-20) assessment Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $24,592	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living: *Demonstrate improvement in ADL scores, as measured by evidence-based and validated assessment tool for the targeted population* Improvement Target:15% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent individual Activities of Daily Living assessment Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $39,408	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living: *Demonstrate improvement in ADL scores, as measured by evidence-based and validated assessment tool for the targeted population* Improvement Target: 20% of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent individual Activities of Daily Living assessment Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $55,524
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $24,592	Year 4 Estimated Outcome Amount: $39,408	Year 5 Estimated Outcome Amount: $55,524
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $119,524			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living

Unique RHP Outcome Identification Number: 133340307.3.4 Pass 1

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

Outcome Measure Description:

OD- 10: Quality Of Life/ Functional Status

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received treatment and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20)Adult Mental Health or Daily Living Activities (DLA-20) Youth Mental Health (Ages 6-18)

Process Milestones:

DY2-5: Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT10.2 15% of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT10.2 20% of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.4

Rationale

Trauma impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor

health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA-20 will help identify areas the trauma has impacted in their lives such as coping skills, problem solving, family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

Outcome measures are based on the number of individuals that have begun treatment in the Trauma Informed Care program and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the number of individuals receiving Trauma Informed Care who show improvement on the DLA-20.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Outcome Measure

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by 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 area avoided). The valuation on this project is based on 90 consumers over the life of the project.

133340307.3.4	*OD10 IT-10.2*	Activities of Daily Living	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.4*		
Starting Point/Baseline:	*Baseline will be individual DLA20 assessment as individuals enter program*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: Activities of Daily Living: Demonstrate improvement in ADL scores, as measured by evidence-based and validated assessment tool, for the target population Improvement Target: 10% of individuals receiving Trauma Informed Care have improvement on subsequent individual Activities of Daily Living (DLA-20) assessment Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $31,100	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living: Demonstrate improvement in ADL scores, as measured by evidence-based and validated assessment tool, for the target population Improvement Target:15% of individuals receiving Trauma Informed Care have improvement on subsequent individual Activities of Daily Living (DLA-20) assessment Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $49,946	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living: Demonstrate improvement in ADL scores, as measured by evidence-based and validated assessment tool, for the target population Improvement Target: 20% of individuals receiving Trauma Informed Care have improvement on subsequent individual Activities of Daily Living (DLA-20) assessment Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $72,385
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $31,100	Year 4 Estimated Outcome Amount: $49,946	Year 5 Estimated Outcome Amount: $72,385
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $153,431			

Title of Outcome Measure (Improvement Target): OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living

Unique RHP Outcome Identification Number: 133340307.3.6 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

- OD-10 Quality of Life/Functional Status
  - IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health.

Process Milestones:

- Not applicable

Outcome Improvement Targets for each year:

- DY2:
  - Not Applicable
- DY3:
  - IT-10.2: 10% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY4:
  - IT-10.2: 15% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY5:
  - IT-10.2: 20% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.5

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Veteran Mental Health services impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a

guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

Outcome measures are based on the number of individuals that are referred from Veteran Peer Support to community based wrap around services and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the number of individuals receiving Veteran Mental Health services who show improvement on the DLA-20 compared to the total number receiving Veteran Mental Health services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 90 individuals receiving veteran mental health services over the life of the project.

133340307.3.6	*IT-10.2*	IT-10.2 Activities of Daily Living/Veteran Mental Health Services	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.5*		
Starting Point/Baseline:	**Baseline will be individual DLA20 assessments as individuals enter program**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: *Activities of Daily Living* Improvement Target: 10% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $81,632	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living Improvement Target:15% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $130,789	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living Improvement Target: 20% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $189,680
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $81,632	Year 4 Estimated Outcome Amount: $130,789	Year 5 Estimated Outcome Amount: $189,680
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $402,101			

Title of Outcome Measure (Improvement Target): IT-10.7 Other Outcome Improvement Target: Traumatic Events Screening Inventory (TESI-C)

Unique RHP Outcome Identification Number: 133340307.3.7 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description
OD-10 Quality of Life/Functional Status
IT-10.7 Other Outcome Improvement Target: Improvement on TESI-C

Numerator: Number of children receiving children's crisis center services with improvement on subsequent Traumatic Events Screening Inventory (TESI-C)

Denominator: Number of children receiving children's crisis center services

Data Source: Patient Records

Rationale: By showing improvement on the TESI-C, the child has shown response to the implemented behavioral supports and is more likely to be successful with a behavioral support plan when returning to their home environment.

Process Milestones for Each Year

N/A

Outcome Improvement Targets for Each Year:

DY 2: N/A

DY 3: At least 10% of consumers served by Children's Mental Health Crisis Center have improved Traumatic Events Screening Inventory on subsequent assessment

DY 4: At least 15% of consumers served by Children's Mental Health Crisis Center have improved Traumatic Events Screening Inventory on subsequent assessment

DY 5: At least 20% of consumers served by Children's Mental Health Crisis Center have improved Traumatic Events Screening Inventory on subsequent assessment

Related Category 1 and Category 2 Unique RHP Project Identifiers *133340307.2.6*

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The Traumatic Events Screening Inventory for Children (TESI-C) protocol is a guide for clinical and/or research interviewing to screen for a child's history of exposure to potentially traumatic experiences. The protocol is designed to help clinicians focus in a systematic fashion on the primary domains of trauma for children, which include direct exposure to or witnessing of severe accidents, illness or disaster, family or community conflict or violence, and sexual molestation. The questions are arranged to hierarchically review experiences in an order that helps the child tolerate the possible stress of disclosing traumatic experiences: gradually increasing the intimacy of the experiences (i.e., sexual trauma is reserved for the end of the interview) and so to help the child recall not only physical harm/violence but also incidents of threatened harm and witnessed trauma. The screening includes 16 items that survey the domains of potential traumatic experiences. Each item rated yes is followed immediately with probes to determine the child and interviewer's view of the life threat/severe injury/risk of severe injury involved and three probes eliciting the child's appraisal of the potentially traumatic incident described for that item.

The TESI-C, an instrument recommended by the National Center for PTSD of the United States Department of Veteran Affairs, is being utilized in this project to determine trauma that impacts a child's mental health status as the trauma must be addressed before the child and family can deal with the mental health issues. According to *How to Manage Trauma,* trauma is a risk factor in nearly all behavioral health and substance use disorders and more than 33% of youths exposed to community violence will experience Post Traumatic Stress Disorder, a very severe reaction to traumatic events.

The reason for the improvement targets (DY2 10%, DY3, 15%, and DY4 20%) is based on the implementation of behavioral changes takes time for consumers to implement and at times consumers may be reluctant to implement such changes.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

By developing a children's mental health crisis center to address children's mental health crisis in the community, the individual will have improved Traumatic Events Screening Inventory, maintain their lives in the community setting and avoid institutionalization. Currently, children within Hill Country's 19 county service area who experience a psychiatric crisis and hospitalized, impact the emergency departments or the criminal justice system, by developing a crisis center for this population, individuals can be diverted to the crisis center and avoid unnecessary utilization of emergency departments and the criminal justice system.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 200 individuals receiving children's crisis center services over the life of the project.

133340307.3.7	*IT-10.7*	Other Outcome Improvement Target: Traumatic Events Screening Inventory	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.6*		
Starting Point/Baseline:	**Baseline will be individual TESI-C assessments as individuals enter program**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.7: Improvement Target: 10% of individuals receiving intervention have improved Traumatic Events Screening Inventory Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $89,795	**Outcome Improvement Target 2** IT-10.7: Improvement Target:15% of individuals receiving intervention have improved Traumatic Events Screening Inventory Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $143,868	**Outcome Improvement Target 3** IT-10.7: Improvement Target: 20% of individuals receiving intervention have improved Traumatic Events Screening Inventory Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $208,648
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $89,795	Year 4 Estimated Outcome Amount: $143,868	Year 5 Estimated Outcome Amount: $208,648
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $442,311			

Title of Outcome Measure (Improvement Target): IT-10.7 Other Outcome Improvement Target: Traumatic Events Screening Inventory (TESI-C)
Unique RHP Outcome Identification Number: 133340307.3.8 Pass 2
Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**
Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description
OD-10 Quality of Life/Functional Status
IT-10.7 Other Outcome Improvement Target: Improvement on the TESI-C

Numerator: Number of children receiving children's crisis center services with improvement on subsequent Traumatic Events Screening Inventory (TESI-C)
Denominator: Number of children receiving children's crisis center services

Process Milestones for Each Year
N/A
Outcome Improvement Targets for Each Year:
DY 2: N/A
DY 3: At least 10% of consumers served by Children's Trauma Informed Care have improved Traumatic Events Screening Inventory on subsequent assessment

DY 4: At least 15% of consumers served by Children's Trauma Informed Care have improved Traumatic Events Screening Inventory on subsequent assessment

DY 5: At least 20% of consumers served by Children's Trauma Informed Care have improved Traumatic Events Screening Inventory on subsequent assessment

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets
The Traumatic Events Screening Inventory for Children (TESI-C) protocol is a guide for clinical and/or research interviewing to screen for a child's history of exposure to potentially traumatic experiences. The protocol is designed to help clinicians focus in a systematic fashion on the primary domains of trauma for children, which include direct exposure to or witnessing of severe accidents, illness or disaster, family or community conflict or violence, and sexual molestation. The questions are arranged to hierarchically review experiences in an order that helps the child tolerate the possible stress of disclosing traumatic experiences: gradually increasing the intimacy of the experiences (i.e., sexual trauma is reserved for the end of the interview) and so to help the child recall not only physical harm/violence but also incidents of threatened harm and witnessed trauma. The screening includes 16 items that survey the domains of potential traumatic experiences. Each item rated yes is followed immediately with probes to determine the child and interviewer's view of the life threat/severe injury/risk of severe injury involved and three probes eliciting the child's appraisal of the potentially traumatic incident described for that item.

The TESI-C is being utilized in this project to determine trauma that impacts a child's mental health status as the trauma must be addressed before the child and family can deal with the mental health issues. According to *How to Manage Trauma,* trauma is a risk factor in nearly all behavioral health and substance use disorders and more than 33% of youths exposed to community violence will experience Post Traumatic Stress Disorder, a very severe reaction to traumatic events.

The reason for the improvement targets (DY2 10%, DY3, 15%, and DY4 20%) is based on the implementation of behavioral changes takes time for consumers to implement and at times consumers may be reluctant to implement such changes.

Briefly describe how the related Category 1 and 2 projects will achieve this outcome measure.

By developing a children's mental health crisis center to address children's mental health crisis in the community, the individual will have improved Traumatic Events Screening Inventory, maintain their lives in the community setting and avoid institutionalization. Currently, children within Hill Country's 19 county service area who experience a psychiatric crisis and hospitalized, impact the emergency departments or the criminal justice system, by developing children's trauma informed care for this population, individuals can be diverted to the crisis center and avoid unnecessary utilization of emergency departments and the criminal justice system.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

The valuation on this project is based on an estimated 60 individuals receiving children's trauma informed care services over the life of the project.

133340307.3.8	*IT-10.7*	Other Outcome Improvement Target: Traumatic Events Screening Inventory	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.7*		
Starting Point/Baseline:	**Baseline will be individual TESI-C assessments as individuals enter program**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.7: Improvement Target: 10% of individuals receiving intervention have improved Traumatic Events Screening Inventory Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $65,306	**Outcome Improvement Target 2** IT-10.7: Improvement Target: 15% of individuals receiving intervention have improved Traumatic Events Screening Inventory Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $104,631	**Outcome Improvement Target 3** IT-10.7: Improvement Target: 20% of individuals receiving intervention have improved Traumatic Events Screening Inventory Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $151,744
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $65,306	Year 4 Estimated Outcome Amount: $104,631	Year 5 Estimated Outcome Amount: $151,744
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $321,681			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Mental Health Courts

Unique RHP Outcome Identification Number: 133340307.3.9 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT-10.2 10% of individuals receiving Mental Health Court services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT-10.2 15% of individuals receiving Mental Health Court services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT-10.2 20% of individuals receiving Mental Health Court services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.8

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Mental Health Court services impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for

intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

Outcome measures are based on the number of individuals participating in Mental Health Court services and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years.

No baseline is set as the measure is associated with the number of individuals receiving Mental Health Court services who show improvement on the DLA-20 compared to the total number receiving Mental Health Court services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-

care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 125 individuals receiving mental health court services over the life of the project.

133340307.3.9	*OD10 IT-10.2*	IT-10.2 Activities of Daily Living/Mental Health Courts	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.8*		
Starting Point/Baseline:	**Baseline will be individual DLA20 assessments as individuals enter program**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: *Activities of Daily Living* Improvement Target: 10% of individuals receiving Mental Health Court services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $51,807	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living Improvement Target:15% of individuals receiving Mental Health Court services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $83,004	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living Improvement Target: 20% of individuals receiving Mental Health Court services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $120,378
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $51,807	Year 4 Estimated Outcome Amount: $83,004	Year 5 Estimated Outcome Amount: $120,378
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $255,189			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Whole Health Peer Support

Unique RHP Outcome Identification Number: 133340307.3.10 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT10.2 10% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT10.2 15% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT10.2 20% of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.9

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Whole Health Peer Support services impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a

guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

Outcome measures are based on the number of individuals participating in Whole Health Peer Support services and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years

No baseline is set as the measure is associated with the number of individuals receiving Mental Health Court services who show improvement on the DLA-20 compared to the total number receiving Mental Health Court services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region

Rationale/Justification for Valuation

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by 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 area avoided). The proposed program's value is based on the average of benefit-cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of $23.36 for every dollar invested. "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

133340307.3.10	*IT-10.2*	Activities of Daily Living/Mental Health Courts	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.9*		
Starting Point/Baseline:	**Baseline will be individual DLA20 assessments as individuals enter program**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: Activities of Daily Living Improvement Target: 10% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR/ Assessment tool Outcome Improvement Target 1 Estimated Incentive Payment*:* $45,539	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living Improvement Target:15% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR/Assessment tool Outcome Improvement Target 2 Estimated Incentive Payment*:* $72,961	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living Improvement Target: 20% of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR/Assessment tool Outcome Improvement Target 3 Estimated Incentive Payment*:* $105,813
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $45,539	Year 4 Estimated Outcome Amount: $72,961	Year 5 Estimated Outcome Amount: $105,813
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $224,313			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Adolescent Whole Health Peer Support

Unique RHP Outcome Identification Number: 133340307.3.11 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

OD-10 Quality of Life/Functional Status
IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20) Adult Mental Health

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT-10.2 10% of individuals receiving Adolescent Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT-10.2 15% of individuals receiving Adolescent Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT-10.2 20% of individuals receiving Adolescent Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.10

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Whole Health Peer Support services impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an

overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

Outcome measures are based on the number of individuals participating in Adolescent Whole Health Peer Support services and were kept modest due to the intervention requiring a change in the individual's lifestyle which will take time to implement and due to individuals continuing to enter the program throughout the demonstration years

No baseline is set as the measure is associated with the number of individuals receiving Mental Health Court services who show improvement on the DLA-20 compared to the total number receiving Mental Health Court services in the program.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by 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 area avoided). The proposed program's value is based on the average of benefit-cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of $23.36 for every dollar invested. "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

133340307.3.11	*IT-10.2*	Activities of Daily Living/ Adolescent Whole Health Peer Support	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.10*		
Starting Point/Baseline:	**Baseline will be individual DLA20 assessments as individuals enter program**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: Activities of Daily Living Improvement Target: 10% of individuals receiving Adolescent Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $34,154	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living Improvement Target:15% of individuals receiving Adolescent Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $54,721	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living Improvement Target: 20% of individuals receiving Adolescent Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $79,360
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $34,154	Year 4 Estimated Outcome Amount: $54,721	Year 5 Estimated Outcome Amount: $79,360
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $168,235			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Family Partner

Unique RHP Outcome Identification Number: 133340307.3.12 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

OD Quality of Life/Functional Status

IT-10.2 Activities of Daily Living – The percentage of individuals in the targeted population who have received mental health services and show improvement on subsequent Activities of Daily Living scales utilizing the Daily Living Activities (DLA-20)

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT-10.2 10% of children of families receiving Family Partner services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY4 IT-10.2 15% of children of families receiving Family Partner services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

DY5 IT-10.2 20% of children of families receiving Family Partner services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.11

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Family Partner Services impacts an individual's mental health and thus their quality of life. It impacts the individual's self care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for

intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 200 individuals receiving Family Partner services over the life of the project.
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133340307.3.12	*IT-10.2*	Activities of Daily Living/Family Partner	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.11*		
Starting Point/Baseline:	**Baseline will be individual DLA20 assessments as individuals enter program**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-10.2: Activities of Daily Living Improvement Target: 10% of children of families receiving Family Partner services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR/Assessment tool Outcome Improvement Target 1 Estimated Incentive Payment*:* $87,754	**Outcome Improvement Target 2** IT-10.2: Activities of Daily Living Improvement Target: 15% of children of families receiving Family Partner services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR/Assessment tool Outcome Improvement Target 2 Estimated Incentive Payment*:* 140,598	**Outcome Improvement Target 3** IT-10.2: Activities of Daily Living Improvement Target: 20% of children of families receiving Family Partner services have improvement on subsequent Activities of Daily Living (DLA-20) Data Source: Hill Country MHDD records/EHR/Assessment tool Outcome Improvement Target 3 Estimated Incentive Payment*:* $203,906
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $87,754	Year 4 Estimated Outcome Amount: $140,598	Year 5 Estimated Outcome Amount: $203,906
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $432,258			

Title of Outcome Measure (Improvement Target): OD-12 Primary Care and Primary Prevention
IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)

Unique RHP Outcome Identification Number: 133340307.3.13 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description
OD-12 Primary Care and Primary Prevention
IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)

Category 3 outcome measures will be based on the following screening categories performed by primary care physicians: PHQ-A/BDI-PC for Adolescents (12-18 years old)

The number of PHQ-A/BDI-PC performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population ages 12 to 18 of Hays County as determined by Texas Department of State Health Services population estimates

Associated Category 3 Measures:
- OD-12 Primary Care & Primary Prevention
  - 133340307.3.14 - IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)
  - 133340307.3.15 - IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

Process Milestones:
- Not applicable

Outcome Improvement Targets for each year:
- DY2 – Not Applicable
- DY3 IT-12.5 2% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment
- DY4 IT-12.5 3% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment
- DY5 IT-12.5 5% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.12

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Screening instruments for depression and substance use disorder are beneficial when behavioral health supports are available. With the addition of Behavioral Health Consultation, it is important that Primary Care Physicians complete assessments to determine individuals needing behavioral health and substance use disorder services in order to begin treatment as soon as possible before symptoms exacerbate. Target percentages were chosen based on a report by the University of Arkansas Medical Sciences Partners in Behavioral Health Sciences that 5% of adolescents age 9 to 17 have major depressive disorder in any given six month span.

Screening for depression and substance use disorder are only recommended when primary care providers have clinical resources to send individuals to for treatment. By providing psychiatric consultation for primary care providers, behavioral health clinicians will be available to assist with early treatment of behavioral health conditions upon completion of screening.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 2000 individuals receiving psychiatric clinical consultation services over the life of the project.

133340307.3.13	*IT-12.5*	*Other USPSTF endorsed screening (PHQ-A and BDI-PC)*	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.12*		
Starting Point/Baseline:	*Service not currently available*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A and BDI-PC) Improvement Target: 2% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment Data Source: Hill Country MHDD records/EHR/Primary Physician Reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $23,100	**Outcome Improvement Target 2** IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A and BDI-PC) Improvement Target: 3% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment Data Source: Hill Country MHDD records/EHR/Primary Physician Reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $37,000	**Outcome Improvement Target 3** IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A and BDI-PC) Improvement Target: 5% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment Data Source: Hill Country MHDD records/EHR/Primary Physician Reports Outcome Improvement Target 3 Estimated Incentive Payment*:* $53,700
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $23,100	Year 4 Estimated Outcome Amount: $37,000	Year 5 Estimated Outcome Amount: $53,700
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $113,800			

Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)

Unique RHP Outcome Identification Number: 133340307.3.14 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description

IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)

Category 3 outcome measures will be based on the following screening categories performed by primary care physicians: PHQ-9 for Major Depression in Adults

The number of PHQ-9 performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Hays County as determined by Texas Department of State Health Services population estimates

Associated Category 3 Measures:

- OD-12 Primary Care & Primary Prevention
  - 133340307.3.13 - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)
  - 133340307.3.15 - IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

Process Milestones:

Not applicable

Outcome Improvement Targets for each year:

DY2 – Not Applicable

DY3 IT12.5 2% of population over 18 years of age have received PHQ-9 assessment

DY4 IT12.5 3% of population over 18 years of age have received PHQ-9 assessment

DY5 IT12.5 5% of population over 18 years of age have received PHQ-9 assessment

Related Category 1 and Category 2 Unique RHP Project Identifiers

133340307.2.12

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Screening instruments for depression and substance use disorder are beneficial when behavioral health supports are available. With the addition of Behavioral Health Consultation, it is important that Primary Care Physicians complete assessments to determine individuals needing behavioral health and substance use disorder services in order to begin treatment as soon as possible before symptoms exacerbate. Target percentages were chosen based on a report by the National Institute of Mental Health showing a prevalence rate for Major Depressive Disorder of 6.7% for the U.S. adult population.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 2000 individuals receiving psychiatric clinical consultation services over the life of the project.

133340307.3.14	*OD12 IT-12.5*	*Other USPSTF endorsed screening (PHQ-9)*	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.12*		
Starting Point/Baseline:	*Service not currently available*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9) Improvement Target: 2% of population over 18 years of age have received PHQ-9 assessment Data Source: Hill Country MHDD records/HER/Primary Physician Reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $23,204	**Outcome Improvement Target 2** IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9) Improvement Target: 3% of population over 18 years of age have received PHQ-9 assessment Data Source: Hill Country MHDD records/HER/Primary Physician Reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $37,197	**Outcome Improvement Target 3** IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9) Improvement Target: 5% of population over 18 years of age have received PHQ-9 assessment Data Source: Hill Country MHDD records/HER/Primary Physician Reports Outcome Improvement Target 3 Estimated Incentive Payment*:* $53,866
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $23,204	Year 4 Estimated Outcome Amount: $37,197	Year 5 Estimated Outcome Amount: $53,866
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $114,267			

Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

Unique RHP Outcome Identification Number: 133340307.3.15 Pass 2

Performing Provider Name: **Hill Country Community MHMR Center (dba Hill Country MHDD Centers)**

Performing Provider TPI: **133340307**

Outcome Measure Description

Overall Outcome Measure Description
IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

Category 3 outcome measures will be based on the following screening categories performed by primary care physicians CAGE and AUDIT for Adult Substance Use Disorder

The number of CAGE/AUDIT performed by Primary Care Physicians on patients/individuals enrolled to receive behavioral health consultation will be divided by the population over 18 of Bandera, Comal, Edwards, Gillespie, Kendall, Kerr, Kinney, Medina, Real, Uvalde and Val Verde as determined by Texas Department of State Health Services population estimates

Associated Category 3 Measures:

- OD-12 Primary Care & Primary Prevention
  - 133340307.3.3 - IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)
  - 133340307.3.4 - IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)

Process Milestones:

- Not applicable

Outcome Improvement Targets for each year:

- DY2 – Not Applicable
- DY3 IT12.5 2% of population over 18 years old have received CAGE/AUDIT assessment
- DY4 IT12.5 3% of population over 18 years old have received CAGE/AUDIT assessment
- DY5 IT12.5 5% of population over 18 years old have received CAGE/AUDIT assessment

Related Category 1 and Category 2 Unique RHP Project Identifiers
133340307.2.12

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Screening instruments for depression and substance use disorder are beneficial when behavioral health supports are available. With the addition of Behavioral Health Consultation, it is important that Primary Care Physicians complete assessments to determine individuals needing behavioral health and substance use disorder services in order to begin treatment as soon as possible before symptoms exacerbate. Target percentages were chosen based on the 2010 National Household Survey on Drug Abuse which showed a 7% prevalence of dependence on alcohol or illicit drugs for individuals 26 years of age or older.

Screening for depression and substance use disorder are only recommended when primary care providers have clinical resources to send individuals to for treatment. By providing psychiatric consultation for primary care providers, behavioral health clinicians will be available to assist with early treatment of behavioral health conditions upon completion of screening.

In addition, throughout the waiver, Hill Country will be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project. The outcome of this project may result in future refinement of the Category 3 Improvement Outcome metrics.

Outcome Measure Valuation

Approach for Valuing Project

Hill Country's approach incorporated the overall valuation of related Category 2 projects, risk associated with achieving the outcome, and the outcome measure's priority for the region.

Rationale/Justification for Valuation

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). The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7
The valuation on this project is based on an estimated 2000 individuals receiving psychiatric clinical consultation services over the life of the project.

133340307.3.15	*OD12 IT-12.5*	*Other USPSTF endorsed screening (CAGE and AUDIT)*	
Hill Country Community MHMR Center (dba Hill Country MHDD Centers)			*133340307*
Related Category 1 or 2 Projects:	*133340307.2.12*		
Starting Point/Baseline:	*Service not currently available*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 IT-12.5: *Other USPSTF endorsed screening (CAGE and AUDIT)* Improvement Target: 2% of population over 18 years of age have received CAGE/AUDIT assessment Data Source: Hill Country MHDD records/HER/Primary Physician Reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $23,100	**Outcome Improvement Target 2** IT-12.5: *Other USPSTF endorsed screening (CAGE and AUDIT)* Improvement Target: 3% of population over 18 years of age have received CAGE/AUDIT assessment Data Source: Hill Country MHDD records/HER/Primary Physician Reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $37,000	**Outcome Improvement Target 3** IT-12.5: *Other USPSTF endorsed screening (CAGE and AUDIT)* Improvement Target: 5% of population over 18 years of age have received CAGE/AUDIT assessment Data Source: Hill Country MHDD records/HER/Primary Physician Reports Outcome Improvement Target 3 Estimated Incentive Payment*:* $53,700
Year 2 Estimated Outcome Amount:	Year 3 Estimated Outcome Amount: $23,100	Year 4 Estimated Outcome Amount: $37,000	Year 5 Estimated Outcome Amount: $53,700
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $113,800			

St. Mark's Medical Center
Category 3 DSRIP Projects

Title of Outcome Measure (Improvement Target): OD-6: IT-6.1 Percent improvement over baseline of patient satisfaction scores.

Unique RHP Outcome Identification Number: 176692501.3.1 Pass 1

Performing Provider Name: St. Mark's Medical Center

Performing Provider TPI #: 176692501

Title of Category 1 or 2 Project: 1.9.2 Improve Access to Specialty Care

Outcome Measure Description

Outcome Measure is IT-6.1, which uses adult CG-CAHPS surveys to report the percent improvement over baseline of patient satisfaction scores. Specifically, St. Mark's will be utilizing the adult CG-CAHPS survey measuring whether patients are getting timely specialty care, appointments, and information.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores. The improvement target will be determined based on baseline numbers established in DY3.
- DY5:
  - IT-6.1 - Percent improvement over baseline of patient satisfaction scores. The improvement target will be determined based on baseline numbers established in DY3.

Rationale: This outcome measure for DY4-DY5 was selected because St. Mark's considers enhanced patient satisfaction/experience to be one of its highest priorities. This outcome measure will provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on care provided by St. Mark's. The surveys enable St. Mark's 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 will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care funded in part by public investment.

For DY2-DY3, St. Mark's selected P-1 and P-3 because it was determined that these steps were necessary in order to institute the appropriate procedures needed to administer the survey and report accurate data over the life of the project. In DY3, we will establish baseline numbers for patient satisfaction.

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

176692501.3.1	IT-6.1	IT-6.1 - Percent improvement over baseline of patient satisfaction scores in targeted patient satisfaction domain - (1) patients are getting timely care, appointments, and information.	
St. Mark's Medical Center			176692501
Related Category 1 or 2 Projects:	176692501.1.1		
Starting Point/Baseline:	Baseline patient satisfaction numbers will be determined in DY 3.		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Planning documents Process Milestone 1 Estimated Incentive Payment*:* $5,237 **Process Milestone 2**: P-3 – Develop and test data systems Data Source: Planning and Testing Documents Process Milestone 2 Estimated Incentive Payment: $5,000	**Process Milestone 3:** P-2 – Establish baseline rates Data Source: Internal Documents and Patient Satisfaction Surveys Process Milestone 3 Estimated Incentive Payment: $10,237	**Outcome Improvement Target 1**: IT-6.1 - Percent improvement over baseline of patient satisfaction scores in targeted patient satisfaction domain - (1) patients are getting timely care, appointments, and information. Improvement Target: TBD based on baseline numbers established in DY3. Data Source: Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $17,000	**Outcome Improvement Target:** IT-6.1 - Percent improvement over baseline of patient satisfaction scores in targeted patient satisfaction domain - (1) patients are getting timely care, appointments, and information. Improvement Target: TBD based on baseline numbers established in DY3. Data Source: Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $26,500
Year 2 Estimated Outcome Amount: $10,237	Year 3 Estimated Outcome Amount: $10,237	Year 4 Estimated Outcome Amount: $17,000	Year 5 Estimated Outcome Amount: $26,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $63,974			

University Medical Center Brackenridge (UMCB)
Category 3 DSRIP Projects

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-3.8 – Behavioral Health/Substance Abuse 30 day readmission rate**

Unique RHP Outcome Identification Number: **137265806.3.4 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT-3.8 – Behavioral Health/Substance Abuse 30 day readmission rate

Process Milestones:

- DY2:
  - P-3 – Develop and test data systems by utilizing the regional Health Information Exchange to determine readmission rates
- DY3:
  - P-2 – Establish baseline rates for the readmission rates for patients where behavioral health or substance abuse is the primary diagnosis

Outcome Improvement Targets for each year:

- DY4: Reduce Behavioral Health/Substance Abuse 30 day readmission rate by 5% below baseline to be determined in DY3.
- DY5: Reduce Behavioral Health/Substance Abuse 30 day readmission rate by 10% below baseline to be determined in DY3.

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.1.1 – PASS 3

Rationale

By creating a community Psychiatric Emergency Department at University Medical Center Brackenridge, we will reduce psychiatric readmissions by 10% by the end of the waiver. This will be accomplished by diverting patients to less intensive levels of care whenever possible by ensuring thorough psychiatric screening for all patients presenting to the Psychiatric Emergency Department in psychiatric crisis.

Outcome Measure Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time,

and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Unique Cat3 ID: 137265806.3.4 – Pass 3	*RHP PP Reference Number 3.IT-3.8*	*Behavioral Health /Substance Abuse 30 day readmission rate*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI: 137265806*
Related Category 1 or 2 Projects::	*Unique Cat2 ID: 137265806.1.1 – PASS 3*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-3]: Develop and test data systems Data Source: Health Information Exchange Process Milestone 1 Estimated Incentive Payment*:* $437,773	**Process Milestone 2** [[P- 2]: Establish baseline rates Data Source: Psychiatric Stakeholders Committee community dashboard P-3]: Develop and test data systems Data Source: Health Information Exchange Process Milestone 2 Estimated Incentive Payment: $533,435	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure)* Improvement Target 1: Reduce the number of readmissions to performing provider's hospital system, for patients 18 years and older, for any cause, within 30 days of discharge when the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis (If an index admission has more than 1 readmission) by 5% over baseline. Data Source: Regional Health Information Exchange Outcome Improvement Target 1 Estimated Incentive Payment*:* $897,255	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate *(Standalone measure)* Improvement Target 2: Reduce the number of readmissions to performing provider's hospital system, for patients 18 years and older, for any cause, within 30 days of discharge when the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis (If an index admission has more than 1 readmission) by 10% over baseline. Data Source: Regional Health Information Exchange Outcome Improvement Target 2 Estimated Incentive Payment*:* $2,133,643
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $437,773	Year 3 Estimated Outcome Amount: $533,435	Year 4 Estimated Outcome Amount: $897,255	Year 5 Estimated Outcome Amount: $2,133,643
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $4,002,106			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-1.18 -Follow-Up After Hospitalization for Mental Illness**

Unique RHP Outcome Identification Number: **137265806.3.5 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT-1.18 - Follow-Up After Hospitalization for Mental Illness

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Process Milestones:

- DY2: P-3 – Develop and test data systems
- DY3: P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4: IT-1.18 Rate 1: Increase the number of patients served by this project who have a follow-up behavioral health appointment within 30 days of discharge from a psychiatric facility by 5% above baseline.
- DY5: IT-1.18 Rate 1: Increase the number of patients served by this project who have a follow-up behavioral health appointment within 30 days of discharge from a psychiatric facility by 10% above baseline.

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.1.2 – Pass 3

Rationale

By expanding the behavioral health post-graduate training programs and behavioral health providers in the community, patients will have better access to outpatient behavioral health providers following an inpatient psychiatric hospitalization. Improved outpatient access further decreases the need for future crisis services (the most expensive services), thereby reducing the healthcare costs for the community. It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE Cat3 ID: 137265806.3.5 – Pass 3	*Ref Number from RHP PP: 3.IT-1.18*	*Follow-up After Hospitalization for Mental Illness*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI – 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.1.2 – Pass 3		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems Data Source: Business Intelligence, Patient Records; Program Analytics Process Milestone 1 Estimated Incentive Payment: $237,811	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Patient Records; Program Analytics Process Milestone 2 Estimated Incentive Payment: $272,132	**Outcome Improvement Target 1** [IT-1.18]: Follow-up After Hospitalization for Mental Illness Improvement Target: Rate 1: Increase the number of patients served by this project who have a follow-up behavioral health appointment within 30 days of discharge from a psychiatric facility located in Travis County by 5% above baseline. Data Source: Patient records, Claims data, HIE Outcome Improvement Target 1 Estimated Incentive Payment: $436,004	**Outcome Improvement Target 2** [IT-1.18]: Follow-up After Hospitalization for Mental Illness Improvement Target: Rate 1: Increase the number of patients served by this project who have a follow-up behavioral health appointment within 30 days of discharge from a psychiatric facility located in Travis County by 10% above baseline. Data Source: Patient records , Claims data, HIE Outcome Improvement Target 2 Estimated Incentive Payment: $1,043,338
Year 2 Estimated Milestone Bundle Amount: $237,811	**Year 3 Estimated Milestone Bundle Amount:** $272,132	**Year 4 Estimated Milestone Bundle Amount:** $436,004	**Year 5 Estimated Milestone Bundle Amount**: $1,043,338
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,989,285			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-3.8 – Behavioral Health/Substance Abuse 30 day readmission rate**

Unique RHP Outcome Identification Number: **137265806.3.6 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT-3.8 – Behavioral Health/Substance Abuse 30 day readmission rate
The percentage of reductions in readmission rates for patients treated for behavioral health/substance abuse

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

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

Process Milestones:

- DY2:
  - [P-3] Develop and test data systems to support IT target
- P-3 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4: [IT-3.8]: Reduce by 3% the baseline 30-day readmission rate for patients served by this project with a principal or secondary diagnosis of a behavioral health disorder and with a complete claims history for the 12-months prior to admission.
- **DY 5:** [IT-3.8]: Reduce by 5% the baseline 30-day readmission rate for patients served by this project with a principal or secondary diagnosis of substance use disorder and with a complete claims history for the 12-months prior to admission.

Related Category 1 and Category 2 Unique RHP Project Identifiers
137265806.1.3 – Pass 3

Rationale

By creating a psychiatric consultation service which provides services via telemedicine capabilities to psychiatric patients, we will reduce psychiatric readmissions. This will be accomplished by diverting patients to less intensive levels of care whenever possible by ensuring thorough psychiatric screening

for all patients presenting to the Emergency Department in psychiatric crisis. A readmission is a negative experience for the patient, resulting in missed work and lower quality of life. It increases the per capita costs of care, and does nothing to improve the health of the general population. A reduction in behavioral health-related admissions for participating inpatients will be a clear sign of this project's effectiveness.

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

The proposed project will improve access to appropriate services sooner when needed, improve overall quality of the services received by the individual, improve long term costs by reducing avoidable hospital admissions. This project will incur costs for telemedicine equipment and the costs of contracting with the telemedicine group in Houston. Cost avoidance will be demonstrated by measuring length of stay and staffing costs for patients with a primary mental health diagnosis in the UMCB ED, avoidable psychiatric admissions, and preventing psychiatric readmissions.

[Unique Category 3 ID]: 137265806.3.6 – Pass 3	*[Reference number from RHP Planning Protocol]* *3.IT – 3.8*	**Behavioral Health /Substance Abuse 30 day readmission rate**	
University Medical Center at Brackenridge (UMCB)			TPI -137265806
Related Category 1 or 2 Projects::	137265806.1.3 – Pass 3		
Starting Point/Baseline:	No service exists		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 3]: Develop and test data systems Data Source: Patient medical records/Program Analyst **Process Milestone 1 Estimated Incentive Payment: $167,650**	**Process Milestone 2** [P- 2]: Establish baseline rates Data Source: Billing data/CPT codes **Process Milestone 2 Estimated Incentive Payment: $191,845**	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate Improvement Target: Reduce the baseline 30-day readmission rate for participating patients by 10% for patients who have been discharged with a principal or secondary diagnosis of a behavioral health/substance abuse disorder and with a complete claims history for the 12-months prior to admission Data Source: Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:* $307,371**	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate Improvement Target: Reduce the baseline 30-day readmission rate for participating patients by 20% for patients who have been discharged with a principal or secondary diagnosis of a behavioral health/substance abuse disorder and with a complete claims history for the 12-months prior to admission Data Source: Program Analytics **Outcome Improvement Target 2 Estimated Incentive Payment*:* $735,524**
Year 2 Estimated Outcome Amount: $167,650	**Year 3 Estimated Outcome Amount: $191,845**	**Year 4 Estimated Outcome Amount: $307,371**	**Year 5 Estimated Outcome Amount: $735,524**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,402,390			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): IT 11.6 Other Outcome Improvement Target

Unique RHP Outcome Identification Number: **137265806.3.7 – PASS 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT-11.6: Other Outcome Improvement Target

The percent of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency. NQMC:005611 [156]

- Numerator - The number of limited English-proficient (LEP) patients with documentation they received both initial assessment and discharge instructions supported by trained and assessed interpreters, or from bilingual providers and bilingual workers/employees assessed for language.

  Inclusions: The number of limited English-proficient (LEP) patients with documentation that they received both initial assessment and discharge instructions supported by:
  - Assessed and trained interpreters, or
  - Bilingual providers or bilingual workers/employee assessed for language proficiency

  Exclusions:

  - Patients receiving initial assessment and/or discharge instructions supported by interpreters who have not met the organization's training and assessment requirements.
  - Patients receiving initial assessment and/or discharge instructions from a bilingual provider or bilingual worker/employee who has not met the organization's training and assessment requirements.
  - Patients receiving initial assessment and/or discharge instructions supported by family or friends.

[156] Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute http://qualitymeasures.ahrq.gov/content.aspx?id=27296

- There is no documentation indicating provision of qualified language services provided at initial assessment and/or discharge instructions

- Denominator - Total number of patients that stated a preference to receive their spoken health care in a language other than English.

Process Milestones:

- DY2:
  - P-2 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - [IT-11.6] Increase by 3% over baseline the percentage of limited English-proficient (LEP) patients with documentation they received both initial assessment and discharge instructions supported by trained and assessed interpreters.
- DY5:
  - [IT-11.6] Increase by 5% over baseline the percentage of limited English-proficient (LEP) patients with documentation they received both initial assessment and discharge instructions supported by trained and assessed interpreters.

Related Category 1 and Category 2 Unique RHP Project Identifiers
137265806.1.4 – Pass 3

Rationale

Interpreter services are frequently provided by untrained individuals, or individuals who have not been assessed for their language proficiency, including family members, friends, and other hospital employees. Research has demonstrated that the likely results of using untrained interpreters or friends, family, and associates are an increase in medical errors, poorer patient-provider communication, and poorer follow-up and adherence to clinical instructions. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or from bilingual employees who are trained and assessed for language and interpretation proficiency during critical times in a patient's health care experience.

Outcome Measure Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to

support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

According to a University of Massachusetts Medical School study, Professional language interpretation and inpatient length of stay and readmission rates, "[t]he length of a hospital stay for LEP patients was significantly longer when professional interpreters were not used at admission or both admission/discharge." In addition, "[p]atients receiving interpretation at admission and/or discharge were less likely than patients receiving no interpretation to be readmitted with 30 days."[157]

[157] **Lindholm M, Hargraves JL, Ferguson WJ, Reed G., Professional language interpretation and inpatient length of stay and readmission rates. Department of Family Medicine and Community Health, University of Massachusetts Medical School. J Gen Intern Med. 2012 Oct;27(10):1294-9. Epub 2012 Apr 18.**

Unique Cat3 ID: 137265806.3.7 – PASS 3	*Ref Number from RHP PP: IT-11.6*	*Other Outcome Improvement Target*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI –137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier: 137265806.1.4 – Pass 3*		
Starting Point/Baseline:	*To be developed 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]: Develop and test data systems Data Source: Business Intelligence, Program Analytics Process Milestone 1 Estimated Incentive Payment: $339,014	**Process Milestone 2** [P-3]: Establish baseline rates Data Source: Patient Records, Program Analytics Process Milestone 2 Estimated Incentive Payment: $387,940	**Outcome Improvement Target 1** [IT-11.6] Increase by 3% over baseline percentage of limited English-proficient (LEP patients with documentation they received both initial assessment and discharge instructions supported by trained and assessed interpreters. Data Source: Program records, interpreter logs Outcome Improvement Target 1 Estimated Incentive Payment: $621,550	**Outcome Improvement Target 2** [IT-11.6] Increase by 5% over baseline percentage of limited English-proficient (LEP patients with documentation they received both initial assessment and discharge instructions supported by trained and assessed interpreters Data Source: Program Analytics, Program records, interpreter logs Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,487,341
Year 2 Estimated Milestone Bundle Amount: $339,014	**Year 3 Estimated Milestone Bundle Amount: $387,940**	**Year 3 Estimated Milestone Bundle Amount: $621,550**	**Year 5 Estimated Milestone Bundle Amount: $1,487,341**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,835,845			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-6.1- Percent improvement over baseline of patient satisfaction scores.**

Unique RHP Outcome Identification Number: **137265806.3.8 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT – 6.1 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.

Process Milestones:

- DY2:
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1-- Increase Percent Improvement over baseline of patient satisfaction scores of UMCB's Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey specific to measurements in the modules Communications with Doctors" and "Communications with Nurses" by 3%.
- DY5:
  - IT-6.1-- Increase Percent Improvement over baseline of patient satisfaction scores of UMCB' s HCAHPS survey specific to measurements in the modules " Communications with Doctors" and "Communications with Nurses" by 5%.

Related Category 1 and Category 2 Unique RHP Project Identifiers
137265806.1.5 – Pass 3

Rationale

The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patient's 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 healthcare by increasing the transparency of the quality of institutional care provided in return for the public investment. The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) specifically

included HCAHPS performance in the calculation of the value-based incentive payment in the Hospital Value-Based Purchasing program, beginning with discharges in October 2012.

The Agency for Healthcare Research and Quality (AHRQ) and the Office of Minority Health (OMH) has put in context diversity and cultural competence in health care by stating, *"The steadily increasing diversity of the population in the United States affects health care providers and institutions. The impact of this diversity means that every day, health care providers encounter, and must learn to manage, complex differences in communication styles, attitudes, expectations, and world views. Health care providers take many different approaches to bridge barriers to communication and understanding that stem from racial, ethnic, cultural and linguistic differences."*

The National Quality Forum (NQF-September 2012) states "one essential step to improving the overall quality of healthcare performance is to eliminate disparities in care experienced by socially disadvantaged population groups. The Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower-quality care than their white counterparts, even after controlling for factors such as insurance, socioeconomic status, co-morbidities, and stage of presentation. Among other factors found to contribute to healthcare disparities are inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate linguistic access. To reduce healthcare disparities, healthcare systems likely will need to improve in all these areas." The IOM report also recommends all healthcare professionals should receive training in cross cultural communication or cultural competence as one of multiple strategies for addressing racial/ethnic disparities in health care.

Cultural Competency Care training has been shown to improve patient satisfaction scores in the targeted domains, contribute to quality of care and outcomes for patients who experience such care. Please note these citations:

1. Hospitals with greater cultural competency have better HCAHPS scores for doctor communication. Furthermore, HCAHPS scores for minorities were higher at hospitals with greater cultural competency on 4 other dimensions: nurse communication, staff responsiveness, quiet room, and pain control. Greater hospital cultural competency may improve overall patient experiences, but may particularly benefit minorities in their interactions with nurses and hospital staff. Such effort may not only serve longstanding goals of reducing racial/ethnic disparities in inpatient experience, but may also contribute to general quality improvement.[158]

2. Empirical support exists for the potential usefulness of the Patient-Centered Culturally Sensitive Health Care Model for explaining the linkage between the provision of patient-centered, culturally sensitive health care, and the health behaviors and outcomes of patients who experience such care.[159]

[158158] *Can hospital cultural competency reduce disparities in patient experiences with care?* Weech-Maldonado R, Elliott M, Pradhan R, Schiller C, Hall A, Hays RD. Department of Health Services Administration, University of Alabama at Birmingham, AL 35294, USA. Med Care. 2012 Nov;50 Suppl:S48-55. doi: 10.1097/MLR.0b013e3182610ad1 www.ncbi.nlm.nih.gov/pubmed/23064277

[159] *Can hospital cultural competency reduce disparities in patient experiences with care?* Weech-Maldonado R, Elliott M, Pradhan R, Schiller C, Hall A, Hays RD. Department of Health Services Administration, University of Alabama at Birmingham, AL

3. *Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition.*
   Wade, Priscilla; Bernstein, Bianca L.
   Journal of Counseling Psychology, Vol 38(1), Jan 1991, 9-15Abstract

   Effects of brief culture sensitivity training for counselors and effects of counselors' race on Black female clients' perceptions of counselor characteristics and the counseling relationship and clients' satisfaction with counseling were examined in an actual counseling situation. Client attrition across 3 sessions was also assessed. Clients assigned to experienced counselors who had received culture sensitivity training rated their counselor higher on credibility and relationship measures, returned for more follow-up sessions, and expressed greater satisfaction with counseling than did clients assigned to experienced counselors who had not received the additional training (control condition). Although same-race counseling dyads resulted in less client attrition, this factor did not influence client perceptions of counselors and the counseling process. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

35294, USA. Med Care. 2012 Nov;50 Suppl:S48-55. doi: 10.1097/MLR.0b013e3182610ad1
www.ncbi.nlm.nih.gov/pubmed/23064277

UNIQUE Cat3 ID: 137265806.3.8 – Pass 3	*Ref Number from RHP PP: 3.IT-6.1*	Percent improvement over baseline of patient satisfaction scores	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI – 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.1.5 – Pass 3		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems Data Source: Business Intelligence, Patient Records; Program Analytics Process Milestone 1 Estimated Incentive Payment: $198,296	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Patient Survey; Program Analytics Process Milestone 2 Estimated Incentive Payment: $226,914	**Milestone 3** [IT-6.1] Percent Improvement Over Baseline of Patient Satisfaction Scores; Modules: *Communications with Doctors* and *Communications with Nurses.* Improvement Target: Increase in HCAHPS scores for target domains of 3% over baseline Data Source: Patient survey (HCAHPS), Program Analytics Milestone 3 Estimated Incentive Payment*:* $363,557	**Milestone 4** [IT-6.1] Percent Improvement Over Baseline of Patient Satisfaction Scores; *Communications with Doctors* and *Communications with Nurses.* Improvement Target: An increase in HCAHPS scores for target domains of 5% over baseline Data Source: Patient survey (HCAHPS), Program Analytics Milestone 4 Estimated Incentive Payment*:* $869,976
Year 2 Estimated Milestone Bundle Amount: $198,296	**Year 3 Estimated Milestone Bundle Amount:** $226,914	**Year 4 Estimated Milestone Bundle Amount:** $363,557	**Year 5 Estimated Milestone Bundle Amount**: $869,976
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,658,743			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-8.1- Timeliness of Prenatal/Postnatal Care**

Unique RHP Outcome Identification Number: **137265806.3.1**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

Overall Outcome Measure Description

IT-8.1- Frequency of ongoing prenatal care

- Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as program enrollee in the first trimester or within 42 days of enrollment in the program.
- Rate 2: Postpartum Care. The percentage of deliveries of program enrollees that had a postpartum visit on or between 21 and 56 days after delivery.

Process Milestones:

- DY2:
  - P-3 – Develop data systems to support outcome improvement targets 1 and 2
- DY3:
  - P-3 – Test data systems to support outcome improvement targets 1 and 2
  - P-2 – Establish baseline rates for targets 1 and 2

Outcome Improvement Targets for each year:

- DY4:
  - IT-8.1 Rate 1: Increase percentage of deliveries of program enrollees that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization by 3% above baseline
  - IT-8.1 Rate 2: Increase the percentage of deliveries of program enrollees that had a postpartum visit on or between 21 and 56 days after delivery by 3% above baseline
- DY5:
  - IT-8.1 Rate 1: Increase percentage of deliveries of program enrollees that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization by 5% above baseline
  - IT-8.1 Rate 2: Increase the percentage of deliveries of program enrollees that had a postpartum visit on or between 21 and 56 days after delivery by 5% above baseline

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.2.1 Pass 1

Rationale

Process milestones – P-3 and P-2 were chosen due to the need to create accurate reports to measure and monitor timeliness of prenatal and postnatal care of patients enrolled in Navigation services. In order to report accurate data and establish baselines, P-3 and P-2 must be approached in DY2-DY3. In DY3, we will establish baselines for targets 1 and 2.

Improvement targets were chosen based on the timeframe of implementation and impact that can be achieved. In addition, the outcome measure being addressed may be affected by social determinants other than prenatal encounters with navigators and providers. For instance, psychosocial and mental health issues, transportation issues, cultural and behavioral issues, and childcare issues will affect a patient's show rate for appointments.

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

This project presents a significant opportunity to increase the number of Hispanic women receiving early prenatal care and postpartum care, and ensure their babies have a medical home. This project will navigate 600 pregnant women and their babies over the course of the Waiver demonstration period.

UNIQUE CATEGORY 3 ID: 137265806.3.1	***Ref Number from RHP PP:*** 3.IT-8.1	***Timeliness of Prenatal/Postnatal Care***	
Performing Provider Name: *University of Medical Center Brackenridge*			***TPI*** *- 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier: 137265806.2.1*		
Starting Point/Baseline:	*To be developed 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-3]: Develop data systems to support Outcome Improvement Target 1 and 2 Data Source: Business Intelligence ***Process Milestone 1 Estimated Incentive Payment:*** $11,376	**Process Milestone 2** [P-3]: Test data systems to support Outcome Improvement Target 1 and 2 Data Source: Business Intelligence ***Process Milestone 2 Estimated Incentive Payment***: $9,676 **Process Milestone 3** [P-2]: Establish baseline rate for Outcome Improvement Target 1 Data Source: Patient Records; Program Analytics ***Process Milestone 3 Estimated Incentive Payment:*** $9,676 **Process Milestone 4** [P-2]: Establish baseline rate for Outcome Improvement Target 2 Data Source: Patient Records; Program Analytics ***Process Milestone 4 Estimated Incentive Payment***: $9,675	**Outcome Improvement Target 1** [IT-8.1, Rate 1]: Timeliness of Prenatal Care Improvement Target: Increase percentage of deliveries of program enrollees that received a prenatal care visit in the first trimester or within 42 days of enrollment in program by 3% above baseline Data Source: Patient Records; Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $21,565 **Outcome Improvement Target 2** [IT-8.1, Rate 2]: Postpartum Care Improvement Target: Increase the percentage of deliveries of program enrollees that had a postpartum visit on or between 21 and 56 days after delivery by 3% above baseline Data Source: Patient Records; Program Analytics	**Outcome Improvement Target 3** [IT-8.1, Rate 1]: Timeliness of Prenatal Care Improvement Target: Increase percentage of deliveries of program enrollees that received a prenatal care visit in the first trimester or within 42 days of enrollment in program by 5% above baseline Data Source: Patient Records; Program Analytics **Outcome Improvement Target 3 Estimated Incentive Payment*:*** $47,443 **Outcome Improvement Target 4** [IT-8.1, Rate 2]: Postpartum Care Improvement Target: Increase the percentage of deliveries of program enrollees that had a postpartum visit on or between 21 and 56 days after delivery by 5% above baseline Data Source: Patient Records; Program Analytics

UNIQUE CATEGORY 3 ID: 137265806.3.1	***Ref Number from RHP PP:*** 3.IT-8.1	***Timeliness of Prenatal/Postnatal Care***	
Performing Provider Name*: University of Medical Center Brackenridge*			***TPI*** *- 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier: 137265806.2.1*		
Starting Point/Baseline:	*To be developed 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)**
		Outcome Improvement Target 2 Estimated Incentive Payment: $21,565	**Outcome Improvement Target 4 Estimated Incentive Payment*:*** $47,443
Year 2 Estimated Milestone Bundle Amount: $11,376	**Year 3 Estimated Milestone Bundle Amount:** $29,027	**Year 4 Estimated Milestone Bundle Amount:** $43,130	**Year 5 Estimated Milestone Bundle Amount:** $94,886
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $178,420			

Title of Outcome Measure (Improvement Target): IT- 8.9 Other Outcome Improvement Target

Unique RHP Outcome Identification Number: 137265806.3.2

Outcome Measure Description:
IT-8.9 Other Outcome Improvement Target
Increase Postpartum Gestational Diabetes Metillus Testing

Process Milestones:

- DY2:
  - o P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - o P-3 – Develop and test data systems
- DY3:
  - o P-3 – Develop and test data systems
  - o P-2 – Establish baseline

Outcome Improvement Targets for each year:

- DY4: Increase by 3% over baseline the percentage of gestational diabetes metillus (GDM) patients receiving diabetes testing prior to 13 weeks post-partum
  - Numerator- GDM patients enrolled in the OB Navigation program receiving a diabetes test 6-12 months postpartum
  - Denominator- All GDM patients enrolled in the OB Navigation program

- DY5: Increase by 5% over baseline the percentage of gestational diabetes metillus patients receiving diabetes testing prior to 13 weeks post-partum
  - Numerator- GDM patients enrolled in the OB Navigation program receiving a diabetes test 6-12 postpartum
  - Denominator- All GDM patients enrolled in the OB Navigation program

Rationale:
In order to report accurate data and establish baselines, P-3 and P-2 must be approached in DY2-DY3. In DY3, we will establish baselines for Target 1.

Between 2.5 percent and 4 percent of women in the United States develop gestational diabetes during pregnancy. Gestational diabetes usually ends after the baby is born, but women with gestational diabetes have up to a 45 percent risk of recurrence with the next pregnancy and up to a 63 percent risk of developing type 2 diabetes later in life. Although expectant mothers with diabetes can and do have normal, healthy pregnancies and deliveries, they are at greater risk for complications such as preeclampsia (a toxic condition in late pregnancy that causes a sudden rise in blood pressure, weight gain and swelling), Cesarean section, and infections. *Diabetes and Women's Health Across the Life Stages* *http://www.cdc.gov/diabetes/pubs/pdf/womenshort.pdf*. Additionally, the children of pregnancies where the mother had gestational diabetes may also be at increased risk for obesity and diabetes." http://ndep.nih.gov/am-i-at-risk/gdm/index.aspx

Once diagnosed with gestational diabetes mellitus (GDM), a woman has a sevenfold increased risk of developing type 2 diabetes relative to women who do not have diabetes during pregnancy. In addition, up to one third of women with GDM have overt diabetes, impaired fasting glucose, or impaired glucose tolerance identified during postpartum glucose screening completed within 6 to 12 weeks. Therefore, the American Diabetes Association, the World Health Organization, and the American College of Obstetricians and Gynecologists currently recommend postpartum glucose screening following GDM. However, despite this recommendation, in many settings the majority of women with GDM fail to return for postpartum glucose testing..
http://www.ncbi.nlm.nih.gov/pubmed/20425588-
This Outcome Measure was selected for this project because diabetes is a major cause of heart disease and stroke. Hispanic Americans and non-Hispanic blacks, have a higher prevalence of diabetes than their white non-Hispanic counterparts. *Diabetes Report Card 2012: National and State Profile of Diabetes and Its Complications*
http://www.cdc.gov/diabetes/pubs/reportcard/diabetes-overview.htm

Outcome Measure Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CATEGORY 3 ID: 137265806.3.2	***Ref Number from RHP PP:*** *3.IT-8.9*	***Other Outcome Improvement Measure: Increase Postpartum diabetes Mellitus Testing***	
Performing Provider Name: *University of Medical Center Brackenridge*			***TPI*** - 137265806
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.1		
Starting Point/Baseline:	*To be developed 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-3]: Develop data systems to support Outcome Improvement Target 1 Data Source: Business Intelligence ***Process Milestone 1 Estimated Incentive Payment:*** $11,376	**Process Milestone 2** [P-3]: Test data systems to support Outcome Improvement Target 1 Data Source: Business Intelligence ***Process Milestone 4 Estimated Incentive Payment:*** $14,513 **Process Milestone 3** [P-5]: Establish baseline rate for Outcome Improvement Target 1 Data Source: Patient Records; Program Analytics ***Process Milestone 3 Estimated Incentive Payment***: $14,513	**Outcome Improvement Target 1** [IT-8.9] Other Outcome Improvement Measure Increase Postpartum Gestational Diabetes Metillus Testing Improvement Target: Increase by 3% the percentage of gestational diabetes metillus (GDM) patients receiving diabetes testing prior to 13 weeks post-partum Numerator- GDM patients enrolled in the OB Navigation program receiving a diabetes test 6-12 months postpartum Denominator- All GDM patients enrolled in the OB Navigation program Data Source: Patient Records, Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $43,131	**Outcome Improvement Target 2** [IT-8.9] Other Outcome Improvement Measure Increase Postpartum Gestational Diabetes Metillus Testing Improvement Target: Increase by 5% the percentage of gestational diabetes metillus (GDM) patients receiving diabetes testing prior to 13 weeks post-partum Numerator- GDM patients enrolled in the OB Navigation program receiving a diabetes test 6-12 months postpartum Denominator- All GDM patients enrolled in the OB Navigation program Data Source: Patient Records, Program Analytics **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $94,887
Year 2 Estimated Milestone Bundle Amount: $11,376	**Year 3 Estimated Milestone Bundle Amount:** $29,027	**Year 4 Estimated Milestone Bundle Amount:** $43,131	**Year 5 Estimated Milestone Bundle Amount**: $94,887
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $178,420			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-12.6 Other Outcome Improvement Target**

Unique RHP Outcome Identification Number: **137265806.3.3 – Pass 2**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

OD-12 Primary Care and Primary Prevention
IT 12.6 Other Outcome Improvement Target:

Rate 1 – Imaging Efficiency Results (NQMC 006362).
Increase the percentage of patients with abnormal mammography screening studies that are followed by a diagnostic mammography ultrasound or MRI of the breast in an outpatient or office setting with 45 days.

Denominator – The number of patients who had a diagnostic mammography study.
Numerator – The number of patients who had a diagnostic mammography study, ultra sound, or MRI of the breast study following a screening study within 45 days.

Rate 2 – Initial Management of abnormal cervical cytology (pap test) and HPV test in adult females (006314).
Increase number of women age 21 years and older with a high-grade squamous intraepithelial lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months.

Denominator: Number of women age 21 years and older with a high-grade squamous intraepithelial lesion cervical cytological result.
Numerator: Number of women age 21 years and older who have a colposcopy with endocervical curettage (ECC) or loop electrosurgical excision (LEE) within six months.

Process Milestones:

- DY2: P-3 Develop and test data systems
- DY3: P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4: IT-12.6
  - *Rate 1*- Increase by 3% over baseline the percentage of patients with mammography screening studies with abnormal results that are followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days.
  - *Rate 2*- Increase by 3% over baseline the percentage of patients with high-grade squamous intraepithelial lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months.

- DY5: IT-12-6
    - *Rate 1*- Increase by 5% over baseline the percentage of patients with mammography screening studies with abnormal results that are followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days
    - *Rate 2*- Increase by 5% over baseline the percentage of patients with high-grade squamous intraepithelial lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months.

Related Category 1 and Category 2 Unique RHP Project Identifiers
137265806.2.2 – Pass 2

Rationale

Rate 2 (NQMC 006314) was selected because it is an evidence-based measure, developed by Institute for Clinical Systems Improvement, that will demonstrate the effectiveness of this DSRIP in regard to cervical cancer screening. [160] Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur.

Navigation from abnormality to definitive diagnosis has been found to save healthcare dollars and benefit time to diagnosis among a racially/ethnically diverse inner city population. Navigators help address the fear and lack of breast health education that play a critical role in preventing women from accessing what, to them, becomes an overwhelming healthcare system.

Outcome Measure Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the

[160] **Initial management of abnormal cervical cytology (Pap test) and HPV test in adult and adolescent females: percentage of women aged 21 years and older with a high-grade squamous intraepithelial lesion (HSIL) cervical cytological result who have a colposcopy with endocervical curettage (ECC) or LEEP within six months.** 2010 Sep. NQMC:006314; Institute for Clinical Systems Improvement - Nonprofit Organization. Collection: Initial Management of Abnormal Cervical Cytology (Pap Test) and HPV Test in Adult and Adolescent Females. See also *ICSI Health Care Guidelines*, Ninth Edition, September 2010. https://www.icsi.org/_asset/hks01y/AbPap-Interact0910.pdf These guidelines are based on this measure and designed to have a clear procedure to encourage 100% follow-up of abnormal Pap smear results.

impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CATEGORY 3 ID: 137265806.3.3 – Pass 2	*Ref Number from RHP PP: 3.IT- 12.6*	*Other Outcome Improvement Target*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI – 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.2 – Pass 2		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems to support Improvement Targets. Data Source: Business Intelligence Process Milestone 1 Estimated Incentive Payment: $ 132,835	**Process Milestone 2 [P-2]**: Establish baseline rates Data Source: Business Intelligence Process Milestone 2 Estimated Incentive Payment: $ 152,005	**Outcome Improvement Target 1** [IT-12.6, Rate 1]: Increase the percentage of patients with abnormal mammography screening studies with abnormal results that are followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days. Improvement Target: Increase by 3% over baseline the percentage of patients with mammography screening studies with abnormal results that are followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days. Data Source: Patient records; program records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $121,770 **Outcome Improvement Target 2** [IT-12.6, Rate 2]: Increase number of women age 21 years and older with a high-grade squamous intraepithelial	**Outcome Improvement Target 3** [IT-12.6, Rate 1]: Increase the percentage of patients with abnormal mammography screening studies with abnormal results that are followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days. Improvement Target: Increase by 5% over baseline the percentage of patients with mammography screening studies with abnormal results that are followed by a diagnostic mammography, ultrasound or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days. Data Source: Patient records; program records. Outcome Improvement Target 3 Estimated Incentive Payment*:* $291,389 **Outcome Improvement Target 4** [IT-12.6, Rate 2]: Increase number of women age 21 years and older with a high-grade squamous intraepithelial

UNIQUE CATEGORY 3 ID: 137265806.3.3 – Pass 2	*Ref Number from RHP PP: 3.IT- 12.6*	*Other Outcome Improvement Target*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI – 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.2 – Pass 2		
Starting Point/Baseline:	*To be developed 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)
		lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months. Improvement Target: Increase by 3% over baseline the percentage of patients with high-grade squamous intraepithelial lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months. Data Source: Patient records; program records. Outcome Improvement Target 2 Estimated Incentive Payment: $121,769	lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months. Improvement Target: Increase by 5% over baseline the percentage of patients with high-grade squamous intraepithelial lesion cervical cytological result who have a colposcopy with endocervical curettage of LEEP within six months. Data Source: Patient records; program records. Outcome Improvement Target 4 Estimated Incentive Payment: $291,389
Year 2 Estimated Milestone Bundle Amount: $ 132,835	**Year 3 Estimated Milestone Bundle Amount: $ 152,005**	**Year 3 Estimated Milestone Bundle Amount: $ 243,539**	**Year 5 Estimated Milestone Bundle Amount: $ 582,778**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,111,157			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate (Standalone Measure)**

Unique RHP Outcome Identification Number: **137265806.3.9 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT-3.8 Behavioral Health/Substance Abuse 30-day readmission rate.
The percentage of reductions in readmission rates for patients treated for behavioral health/substance abuse

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

d. 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

Process Milestones:

- DY2: [P-3] Develop and test data systems to support IT target.
- DY3: [P-2] Establish baseline rates.

Outcome Improvement Targets for each year:

DY4: IT-3.8]: Reduce by 3% the baseline 30-day readmission rate for participating UMCB inpatients with a principal or secondary diagnosis of substance use disorder and with a complete claims history for the 12-months prior to admission.

DY 5: [IT-3.8]: Reduce by 5% the baseline 30-day readmission rate for participating UMCB inpatients with a principal or secondary diagnosis of substance use disorder and with a complete claims history for the 12-months prior to admission.

Related Category 1 and Category 2 Unique RHP Project Identifiers
137265806.2.3 – Pass 3

Rationale

The milestones selected address the progressive design and implementation of the Substance Use Disorder Navigation project, and the resulting progress toward reducing readmission rates. DY2 is the development of the process and data systems to be used to track the readmissions of patients enrolled in the program. Beginning with DY3 and the hiring of the staff that will implement the project, the goal is to begin reducing the readmission rate as the result of transitioning care in a manner that addresses on an ongoing basis rather than in the acute environment.

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE Cat3 ID: 137265806.3.9 – Pass 3	*Ref Number from RHP PP: 3.IT-3.8*	Behavioral Health/Substance Abuse 30-day Readmission Rate	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI – 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier: 137265806.2.3 – Pass 3*		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/130/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3]: Develop and test data systems to support IT target. Data Source: Business Intelligence Process Milestone 1 Estimated Incentive Payment: $162,603	**Process Milestone 2** [P-2]: Establish Baseline Rate for Improvement Targets based on specific population served by the project. Data Source: Program analytics and patient records Process Milestone 1 Estimated Incentive Payment*:* $186,070	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health/Substance Abuse 30 day readmission rate. Improvement Target: Reduce the baseline 30-day readmission rate for participating UMCB inpatients by 3% for patients who have been discharged with a principal or secondary diagnosis of substance abuse disorder and with a complete claims history for the 12-months prior to admission Data Source: Program Analytics and patient records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $298,117	**Outcome Improvement Target 2** [IT- 3.8]: Behavioral Health/Substance Abuse 30 day readmission rate. Improvement Target: Reduce the baseline 30-day readmission rate for participating UMCB inpatients by 5% for patients who have been discharged with a principal or secondary diagnosis of substance abuse disorder and with a complete claims history for the 12-months prior to admission. Data Source: Program Analytics and patient records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $713,382
Year 2 Estimated Milestone Bundle Amount: $162,603	**Year 3 Estimated Milestone Bundle Amount:** $186,070	**Year 3 Estimated Milestone Bundle Amount:** $298,117	**Year 5 Estimated Milestone Bundle Amount**: $713,382
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,360,172			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate**

Unique RHP Outcome Identification Number: **137265806.3.10 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

Overall Outcome Measure Description

IT - 3.8 - Behavioral Health/Substance Abuse 30 day readmission rate
The percentage of reductions in readmission rates for patients treated for behavioral health/substance abuse

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

f. 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

Process Milestones:

- DY2: [P-3] Develop and test data systems to support IT target.
- DY3: [P-2] Establish baseline rates.

Outcome Improvement Targets for each year:

DY4: [IT-3.8]: Reduce by 3% the baseline 30-day readmission rate for participating UMCB inpatients with a principal or secondary diagnosis of substance use disorder and with a complete claims history for the 12-months prior to admission.

DY 5: [IT-3.8]: Reduce by 5% the baseline 30-day readmission rate for participating UMCB inpatients with a principal or secondary diagnosis of substance use disorder and with a complete claims history for the 12-months prior to admission.

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.2.4 – Pass 3

Rationale

Interventions such as assessment of behavioral health needs as a community initiative and linking patients with appropriate resources will lead to less hospital admissions and readmissions related to behavioral health.

The goals of the waiver are summarized through the triple aims of:

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care

The readmission rate for patients with a mental health disorder is currently very high. A hospital admission that might have been avoided with preemptive intervention is contrary to the. A readmission is a negative experience for the patient, resulting in missed work and lower quality of life. It increases the per capita costs of care, and does nothing to improve the health of the general population. A reduction in behavioral health-related admissions for participating inpatients will be a clear sign of its effectiveness.

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

The milestones selected address the progressive design and implementation of the Behavioral Health Navigation project. DY2 is the development of the process and data systems to be used to complete, record, and monitor the assessment and consultation encounters. DY3 establishes the baseline rates through roll out of the service to UMCB. DY4 and DY5 targets are focused on the avoidance of 30-day readmission for individuals who have received the behavioral health consultation.

Outcome Measure Valuation

The Behavioral Health Assessment and Resource Navigation program will provide a comprehensive behavioral health needs assessment for the targeted population at a rate of 50 per month for a total of 1,800 assessments over the life of the project. As the average cost for a single emergency department encounter is $693.75, the potential cost avoidance for the targeted population served through this project will be approximately $1,123,875. This figure is based on 90% of patients assessed and enrolled in Resource Navigation avoidance of seeking treatment at Seton medical/surgical emergency departments or hospitalization within 30 days of assessment.

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CAT3 ID: 137265806.3.10 – Pass 3	*Ref Number from RHP PP: 3.IT-3.8*	*Behavioral Health/Substance Abuse Disorder 30-day Readmission Rate*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI – 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.4 – Pass 3		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems to support IT target. Data Source: Business Intelligence Process Milestone 1 Estimated Incentive Payment: $161,388	**Process Milestone 2 [P-2]:** Establish baseline rates. Data Source: Business Intelligence Process Milestone 2 Estimated Incentive Payment: $184,679	**Outcome Improvement Target 1 [IT-3.8]:** Behavioral Health/Substance Abuse 30 day readmission rate. Improvement Target: Reduce the baseline 30-day readmission rate for participating UMCB inpatients by 3% for patients who have been discharged with a principal or secondary diagnosis of substance abuse disorder and with a complete claims history for the 12-months prior to admission Data Source: Program Analytics and patient records. Outcome Improvement Target 1 Estimated Incentive Payment*:* $295,888	**Outcome Improvement Target 2 [IT- 3.8]** Behavioral Health/Substance Abuse 30 day readmission rate. Improvement Target: Reduce the baseline 30-day readmission rate for participating UMCB inpatients by 3% for patients who have been discharged with a principal or secondary diagnosis of substance abuse disorder and with a complete claims history for the 12-months prior to admission Data Source: Program Analytics and patient records. Outcome Improvement Target 2 Estimated Incentive Payment*:* $708,048
Year 2 Estimated Milestone Bundle Amount: $161,388	**Year 3 Estimated Milestone Bundle Amount:** $184,679	**Year 3 Estimated Milestone Bundle Amount:** $295,888	**Year 5 Estimated Milestone Bundle Amount**: $708,048
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,350,003			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-9.2 - ED Appropriate Utilization**

Unique RHP Outcome Identification Number: **137265806.3.11– Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **13725806**

Outcome Measure Description

Overall Outcome Measure Description

- IT-9.2 ED appropriate utilization (Standalone measure)
  Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - Chronic Obstructive Pulmonary Disease
  - Asthma

Process Milestones:

DY2: P- 3 Develop and test data systems to support Outcome Improvement Targets

DY3: P- 2 Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - Reduce Emergency Department visits for target conditions: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma by 5% below baseline for the patients served by the project.
- DY5:
  - Reduce Emergency Department visits for target conditions: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma by 10% below baseline for the served by the project.

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.2.5 – Pass 3

Rationale

Reasons for Selecting the Process Milestones and Outcome Improvement Targets

Transitional care programs while equipped to support effective transitions for all patients tend to serve best those patients with a high propensity for frequent ambulatory sensitive admissions. This measure will provide a significant indication of the value of the care transitions program.

Effective management of transitions in care has been shown to reduce inappropriate hospitalization and inappropriate use of emergency departments for the treatment of chronic illness. Measuring the incidence of emergency department use is an effective measure of the impact of a CTI program.

Outcome Measure Valuation

Financial value of the reduction in ambulatory sensitive acute care visits. The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CAT3 ID: 137265806.3.11 – Pass 3	*Ref Number from RHP PP: 3.IT-9.2*	*ED appropriate utilization*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI – 137265806*
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.5 – Pass 3		
Starting Point/Baseline:	*To be developed 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-3 Develop and test data systems Data Source: Business Intelligence, Patient Records **Process Milestone 1 Estimated Incentive Payment: $433,210**	**Process Milestone 2** P- 2 Establish baseline rates Data Source: Business Intelligence, Patient records **Process Milestone 2 Estimated Incentive Payment: $ 495,730**	**Outcome Improvement Target 1** IT-9.2 ED appropriate utilization Improvement Target: Reduce Emergency Department visits for target conditions by 5% below baseline. Data Source: Patient Records, Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:*** **$794,248**	**Outcome Improvement Target 2** IT-9.2 ED appropriate utilization Improvement Target: Reduce Emergency Department visits for target conditions by 10% below baseline. Data Source: Patient Records, Program Analytics **Outcome Improvement Target 2 Estimated Incentive Payment*:*** **$1,900,600**
Year 2 Estimated Milestone Bundle Amount: $433,210	**Year 3 Estimated Milestone Bundle Amount:** $495,730	**Year 3 Estimated Milestone Bundle Amount:** $794,248	**Year 5 Estimated Milestone Bundle Amount**: $1,900,600
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,623,788			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-9.2 ED Appropriate Utilization**
Unique RHP Outcome Identification Number: **137265806.3.12 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

Overall Outcome Measure Description

- IT-9.2 ED appropriate utilization (Standalone measure)
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Process Milestones:

- DY2: P- 3 Develop and test data systems
- DY3: P- 2 Establish baseline rates

Outcome Improvement Targets for each year:

Outcome Improvement Targets for each year:

- DY4:
    - IT-9.2 Reduce Emergency Department visits for target conditions: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma by 5% below baseline for program enrollees.
- DY5:
    - IT-9.2 Reduce Emergency Department visits for target conditions: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma by 10% below baseline for program enrollees.

Related Category 1 and Category 2 Unique RHP Project Identifiers
137265806.2.6 – Pass 3

Rationale

Effective management of chronic disease has been shown to reduce inappropriate hospitalization and inappropriate use of emergency department for the treatment of targeted conditions. Measuring the incidence of emergency department use is an effective measure of the impact of this program.

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Unique Cat3 ID: 137265806.3.12 – Pass 3	*Ref Number from RHP PP: 3.IT-9.2*	*ED Appropriate Utilization*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI* – 137265806
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.6 – Pass 3		
Starting Point/Baseline:	*To be developed 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-3] Develop and test data systems; patient records Data Source: Business Intelligence, Process Milestone 1 Estimated Incentive Payment: $483,891	**Process Milestone 2** [P-2] Establish baseline rates Data Source: Business Intelligence, patient records Process Milestone 2 Estimated Incentive Payment: $276,862	**Outcome Improvement Target 1** [IT-9.2] Reduce Emergency Department visits for target conditions: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma by 5% below baseline for program enrollees. Data Source: Medical records, Program Analytics Outcome Improvement Target 1 Estimated Incentive Payment: $887,167	**Outcome Improvement Target 2** [IT-9.2] Reduce Emergency Department visits for target conditions: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma by 10% below baseline for program enrollees. Data Source: Medical records, Program Analytics Outcome Improvement Target 2 Estimated Incentive Payment: $2,122,952
Year 2 Estimated Milestone Bundle Amount: $483,891	**Year 3 Estimated Milestone Bundle Amount:** $553,725	**Year 3 Estimated Milestone Bundle Amount:** $887,167	**Year 5 Estimated Milestone Bundle Amount**: $2,122,952
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,047,735			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-13.1 Pain Assessment (NQF 1637)**

Unique RHP Outcome Identification Number: **137265806.3.13 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

Overall Outcome Measure Description

IT-13.1 Pain assessment (NQF 1637) - Percentage of hospice or PC patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

Process Milestones:

- DY2:
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates for target improvement

Outcome Improvement Targets for each year:

- DY4:
  - IT-13.1: Increase percentage of hospice or PC patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by 5% above baseline
- DY5:
  - IT-13.1: Increase percentage of hospice or PC patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by 8% above baseline

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.2.7 – Pass 3

Rationale

Pain is under-recognized and under-treated by clinicians, resulting in excess suffering from patients with serious illness. When pain is managed by a team with expertise in this area over 90% of the time the patient's pain is decreased to an acceptable level without having to have surgery or invasive procedures to achieve this pain reduction. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.

Outcome Measure Valuation:
The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CAT3 ID: 137265806.3.13 – Pass 3	*Ref Number from RHP PP: 3.IT-13.1*	*Pain assessment (NQF 1637)*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			TPI - 137265806
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier: 137265806.2.7 – Pass 3*		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems Data Source: Business Intelligence **Process Milestone 1 Estimated Incentive Payment:** $61,444	**Process Milestone 2** [P-2]: Establish baseline rate Data Source: Patient Records; Program Analytics **Process Milestone 2 Estimated Incentive Payment**: $70,311	**Outcome Improvement Target 1** IT-13.1: Improvement Target: Increase percentage of hospice or PC patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by 5% above baseline Data Source: Patient Records, Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $112,651	**Outcome Improvement Target 2** IT-13.1: Improvement Target: Increase percentage of hospice or PC patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by 8% above baseline Data Source: Patient Records, Program Analytics **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $269,569
Year 2 Estimated Milestone Bundle Amount: $61,444	**Year 3 Estimated Milestone Bundle Amount:** $70,311	**Year 3 Estimated Milestone Bundle Amount:** $112,651	**Year 5 Estimated Milestone Bundle Amount**: $269,569
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $513,975			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-13.2 Treatment Preferences (NQF 1641)**

Unique RHP Outcome Identification Number: **137265806.3.14 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT-13.2Treatment Preferences (NQF 1641) Percentage of patients with chart documentation of preferences for life sustaining treatments.

Process Milestones:

- DY2:
  - P-3 – Develop and test data systems
- DY3:
  - P-2 – Establish baseline rates for target improvement

Outcome Improvement Targets for each year:

- DY4:
  - IT-13.2: Increase the percentage of seriously ill patients enrolled in hospice OR receiving specialty PC in an acute hospital setting with chart documentation of preferences for life sustaining treatments by 7% above baseline
- DY5:
  - IT-13.2: Increase the percentage of seriously ill patients enrolled in hospice OR receiving specialty PC in an acute hospital setting with chart documentation of preferences for life sustaining treatments by 10% above baseline

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.2.7 – Pass 3

Rationale

Treatment Preferences was chosen because research has shown that when trained professionals have conversations with patients and their families about treatment preferences, and the patient/family wishes are followed, symptom scores diminish, quality of life scores improve, family/caregiver stress lessens, fewer healthcare resources are consumed, and cost of care declines. Advance directives have shown to assure patient preferences are followed, decrease family/caregiver stress, and decrease costs of care. The focus of ensuring that patients have documentation of preferences for life sustaining treatments in their chart, will assist in identifying patients who should be enrolled in

Palliative Care in an acute hospital setting, help communicate the patient preferences to all Physicians involved in care and will help focus on the patient centered decision making.

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CATEGORY 3 ID: 137265806.3.14 – Pass 3	3.IT-13.2	**Name of IT:** Treatment Preferences (NQF 1641)	
Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**			*TPI* –137265806
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.7 – Pass 3		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems Data Source: Business Intelligence **Process Milestone 1 Estimated Incentive Payment:** $61,444	**Process Milestone 2** [P-2]: Establish baseline rate Data Source: Patient Records; Program Analytics **Process Milestone 2 Estimated Incentive Payment**: $70,311	**Outcome Improvement Target 1** IT-13.2: Improvement Target: Increase the percentage of seriously ill patients enrolled in hospice OR receiving specialty PC in an acute hospital setting with chart documentation of preferences for life sustaining treatments by 7% above baseline Data Source: Patient Records, Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $112,651	**Outcome Improvement Target 2** IT-13.2: Improvement Target: Increase the percentage of seriously ill patients enrolled in hospice OR receiving specialty PC in an acute hospital setting with chart documentation of preferences for life sustaining treatments by 10% above baseline Data Source: Patient Records, Program Analytics **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $269,569
Year 2 Estimated Milestone Bundle Amount: $61,444	**Year 3 Estimated Milestone Bundle Amount:** $70,311	**Year 3 Estimated Milestone Bundle Amount:** $112,651	**Year 5 Estimated Milestone Bundle Amount**: $269,569
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $513,975			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-13.6 Other Outcome Improvement Target (NQMC:002702)**

Unique RHP Outcome Identification Number: **137265806.3.15 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

IT-13.6 Other Outcome Improvement Target
Percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission. 2006 Sept NQMC:002702 , VHA, Inc.[161]

Numerator Inclusions/Exclusions

Inclusions
Number of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of intensive care unit (ICU) admission

- Documentation must be in the medical record.
- Definition of Interdisciplinary: Involved at least the attending physician (either primary attending or ICU attending), a member of another discipline (nurse, social worker, or pastoral care representative), and the patient (and/or family). Whenever possible, a nurse should be involved along with the physician.
- Definition of Family Meeting: A discussion addressing each of the following topics is recommended:
    1. the patient's condition (diagnosis and prognosis),
    2. goals of treatment,
    3. the patient's and family's needs and preferences (could address preparation of an advance directive, if not already done),
    4. the patient's and family's understanding of the patient's condition and goals of treatment at the conclusion of the meeting.
- For patients who were not visited by a family member on or before Day Five of the ICU admission, the indicator applies only to an interdisciplinary meeting with the patient. For patients who lack capacity to participate in such a meeting, the indicator applies only to an interdisciplinary meeting with the family. If the patient lacks the capacity to

[161] .<http://www.qualitymeasures.ahrq.gov/content.aspx?id=28315&search=palliative+care

participate in such a meeting, the family meeting takes place in a space other than at the bedside.

Exclusions**:**
Unspecified

Denominator Inclusions/Exclusions

Inclusions
Total number of patients with an intensive care unit (ICU) length of stay greater than or equal to 5 days

Exclusions

- Patients discharged (or transferred out of the ICU) on or before Day Five of ICU admission.
- Patients expired on or before Day Five of ICU admission.
- Patients who were not visited by a family member on or before Day Five of ICU admission AND who lack capacity to participate in such a meeting.
- Patient and family refused to participate in an interdisciplinary meeting.

Note: The day of ICU admission is considered Day Zero and the following calendar day beginning at 0001 hours is considered Day One

Process Milestones:

- DY2:
  - P-3 – Develop and test data

  DY3:
  - P-2 – Establish baseline rates for target improvement

Outcome Improvement Targets for each year:

- DY4:
  Increase the percent patients ___ above baseline who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission.

- DY5:
  Increase the percent patients ___ above baseline who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission.

Related Category 1 and Category 2 Unique RHP Project Identifiers
137265806.2.7 – Pass 3

Rationale

This measure was chosen because Palliative care focuses on prevention and relief of suffering, improving communication, between treatment and individual preferences, and facilitating transitions across care settings for patients with life threatening illness and their families. As such, it is increasingly accepted as an integral component of comprehensive intensive care unit (ICU) care for all critically ill patients, including those pursuing every reasonable treatment to prolong life. At the same time, evidence has accumulated that the quality of ICU palliative care needs improvement: patients experience high levels of pain and other distressing symptoms; families fail to understand basic information about diagnosis, prognosis, or critical care treatments and experience high levels of depression and anxiety; care plans diverge from patients' and families' preferences; and conflict among ICU clinicians, patients, and families is common.

The Institute of Medicine identified improvement of palliative care in the ICU and other care settings as a national health priority. For all healthcare providers and fields, it has also prioritized "closing the gap" between the current knowledge of optimal care and current clinical practice.
This measure is one of ten measures included in a palliative care bundle intended to close the "quality gap" between existing best evidence and current daily practice.

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Outcome Measure Valuation

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to

support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

UNIQUE CATEGORY 3 ID: 137265806.3.15 – Pass 3	3.IT-13.4	**Name of IT:** Proportion admitted to the ICU in the last 30 days of life (NQF 0213)	
Performing Provider Name: **University Medical Center at Brackenridge (UMCB)**			TPI -137265806
Related Category 1 or 2 Projects:	*Unique Category 2 Identifier:* 137265806.2.7 – Pass 3		
Starting Point/Baseline:	*To be developed 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-3]: Develop and test data systems Data Source: Business Intelligence ***Process Milestone 1 Estimated Incentive Payment:*** $61,444	**Process Milestone 2** [P-2]: Establish baseline rate Data Source: Patient Records; Program Analytics **Process Milestone 2 Estimated Incentive Payment**: $70,311	**Outcome Improvement Target 1** [IT-13.6] Other Outcome Improvement Target - Percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission Improvement Target: Increase the percent patients ___ above baseline who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission Data Source: Patient Records, Program Analytics **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $112,651	**Outcome Improvement Target 2** [IT-13.6] Other Outcome Improvement Target - Percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission Improvement Target: Increase the percent patients ___ above baseline who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission Data Source: Patient Records, Program Analytics **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $269,569
Year 2 Estimated Milestone Bundle Amount: $61,444	**Year 3 Estimated Milestone Bundle Amount:** $70,311	**Year 3 Estimated Milestone Bundle Amount:** $112,651	**Year 5 Estimated Milestone Bundle Amount**: $269,569
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $513,975			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **IT-6.1 - Percent improvement over baseline of patient satisfaction scores. IT-9.2 ED Appropriate Utilization**

Unique RHP Outcome Identification Number: **137265806.3.16 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge**

Performing Provider TPI: **137265806**

Outcome Measure Description

OD-9 Right Care, Right Setting
IT-9.2 ED appropriate utilization: reduce all ED visits

Process Milestones

- DY 2
  - [P-3]: Develop and test data systems
- DY 3
  - [P-2]: Establish baseline rates

Improvement Targets

- DY 4
  - [IT-9.2] Reduce ED utilization for program participants by 3% below baseline determined in DY3.
- DY 5
  - [IT-9.2] Reduce ED utilization for program participants by 5% below baseline determined in DY3.

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.2.8

Rationale

This measure was selected because interventions by navigators can help reduce ED use. EDs are often used by patients with cancer for disease or treatment-related problems and unrelated issues. The Institute of Medicine report on ensuring quality cancer care provided a review of cancer services and delivery systems and identified a "wide gulf between what could be construed as the ideal and the reality of their experience with cancer care."[162] One recommendation from the report was the need to conduct studies on why segments of the population do not receive appropriate cancer care. Visiting the ED may be considered appropriate care when assessing and managing acute onset problems but may also reflect problems not adequately addressed or managed during routine

[162] Hewitt M, Simone JV, editors. Ensuring Quality Cancer Care. Washington, DC: National Academies Press; 1999.

cancer care.[163] In addition, EDs are often overcrowded and are providing care to larger numbers of patients; this might not be the best environment for oncology patients with urgent care needs.

Interventions by navigators are expected to reduce ER use. Nursing intervention focusing on educating cancer patients regarding specific strategies for controlling symptoms may be worthwhile, as the patients may regain some control in managing their symptoms and thus ultimately require fewer ED and hospital visits. Such a straightforward approach may empower patients, enhance their quality of life and reduce overall costs of cancer care.[164] Nurses can help ensure common reasons for ED usage are addressed, e.g. pain, GI symptoms and prevent symptoms from escalating to the need for ED service. They also can provide education on how to recognize infection and help empower them to control symptoms and thus reduce ED use.[165] By providing the navigation services provided by this project, we expect the incidence of ED by program participants to decline and the use of this measure an effective measure of the impact of this program.

Outcome Measure Valuation:

The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

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[163] Barbera L, Paszat L, Chartier C. Indicators of poor quality end-of-life cancer care in Ontario. J Palliat Care. 2006;22:12–17. [PubMed]

[164] Med Sci Monit. 2006 Jul;12(7):CR319-24. Epub 2006 Jun 28.

[165] Clin Oncol. 2011 July 1; 29(19): 2683–2688.

Unique Cat3 ID: 137265806.3.16	*Ref Number from RHP PP: 3.IT*	[IT 9.2 ED appropriate utilization	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI - 137265806*
Related Category 1 or 2 Projects:	*Unique Cat2 ID: 137265806.2.8*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-3]: Develop and test data systems Data Source: Business Intelligence, Patient Records; Program Analytics Process Milestone 1 Estimated Incentive Payment: $67,027	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Patient Records; Program Analytics Process Milestone 3 Estimated Incentive Payment: $153,401	**Outcome Improvement Target 1** [IT 9.2]: Reduce Emergency Department visits for program participants by 3% below baseline for program enrollees. Outcome Improvement Target 1 Estimated Incentive Payment*:* $245,775	**Outcome Improvement Target 2** [IT 9.2]: Reduce Emergency Department visits for program participants by 5% below baseline for program enrollees. Outcome Improvement Target 2 Estimated Incentive Payment*:* $588,129
Year 2 Estimated Milestone Bundle Amount: $134,054	**Year 3 Estimated Milestone Bundle Amount: $ 153,401**	**Year 3 Estimated Milestone Bundle Amount: $ 245,775**	**Year 5 Estimated Milestone Bundle Amount: $ 588,129**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 1,121,359			

Identifying Project and Provider Information

Title of Outcome Measure (Improvement Target): **Diabetes 30 Day Readmission Rate**

Unique RHP Outcome Identification Number: **137265806.3.17 – Pass 3**

Performing Provider Name: **University Medical Center Brackenridge (UMCB)**

Performing Provider TPI: **137265806**

Outcome Measure Description

Overall Outcome Measure Description

IT-3.3 – Diabetes 30 Day Readmission Rate

Numerator: The number of readmissions (patients 18 years and older), for any cause within 30 days of discharge from the index diabetes admission. If an index admission has more than one readmission, only the first is counted.

Denominator: The number of admissions (for patients 18 years and older), 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.

Process Milestones:

- DY2:
  - P-3 – Develop and test data systems.
- DY3:
  - P-2 – Establish baseline rates.

Outcome Improvement Targets for each year:

- **DY4:**
  - [IT-33] Decrease by 3% the baseline 30-day readmissions rate for program participants.
- **DY5:**
  - [IT-33] Decrease by 5% the baseline 30-day readmissions rate for program participants.

Related Category 1 and Category 2 Unique RHP Project Identifiers

137265806.2.9

Rationale

Hospitals are providing care for an increasing number of patients diagnosed with diabetes. Often, these patients enter the healthcare system with a serious complication of diabetes such as a heart

attack, without knowing that the underlying cause was undiagnosed diabetes. Further, even with knowledge of the condition, many diabetics enter the hospital because of a lack of care or training regarding self-management. These patients rely on the services of the experts in the hospital to help them understand their disease and understand their medication regime and assist with discharge planning and follow-up health care.

In a system that is already struggling with the resources to provide all of the needed inpatient services, it is difficult to find resources to also provide education and post-discharge planning. As a result, many diabetes patients are readmitted to the hospital for reasons such as non-adherence to medications, financial difficulties with medical care costs, and a lack of understanding of discharge care plan and lack of follow-up with a healthcare provider. The interdisciplinary model works towards effectively enhancing this system and its primary goal is to decrease the diabetes 30-day readmission rates by implementing process improvements to the system and across the continuum of care.

Improvement targets were chosen based on our expectation that the program will have a significant impact on patient compliance with post-discharge recommendations for self management, and on engagement with primary care providers. If we are successful, readmissions should be reduced.

Outcome Measure Valuation

Project valuation considered costs, cost avoidance, population impact, overall impact to the community, as well as the projects ability to transform diabetes care by provided evidenced based patient centered care during point of contact, involving the patient in learning, participation in skill training, exposing them to the benefits of lifestyle management, and behavior change throughout the hospitalization.

Financial value of the reduction in ambulatory sensitive acute care visits. The project is valued using a method which ranks the importance of each project based on four factors: (1) the required investment size, which considered costs, personnel, space, equipment, time, and complexity; (2) the project's scope, which included the number of patients affected, number patient encounters, and/or additional providers recruited/trained; ripple effect on all providers; (3) the project's ability to transform healthcare by providing the right care, at the right place, the right time, and in cost effective manner; and (4) the amount of local government funding available to support the project. This approach best addresses the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Unique Cat3 ID:137265806.3.17 – Pass 3	*Ref Number from RHP PP: 3.IT-3.3*	*Diabetes 30 day readmission rate*	
Performing Provider Name: University Medical Center at Brackenridge (UMCB)			*TPI - 137265806*
Related Category 1 or 2 Projects::	*Unique Cat2 ID: 137265806.2.9 – Pass 3*		
Starting Point/Baseline:	*To be developed 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-3] Develop and test data system. Data Source: Patient records; program analytics. **Process Milestone 1 Estimated Incentive Payment $317,427**	**Process Milestone 2** [P- 2]: Establish baseline rates Data Source: Patient records; program analytics. **Process Milestone 2 Estimated Incentive Payment*:* $363,237**	**Outcome Improvement Target 1** [IT-3.3]: Diabetes 30 day readmission rate Improvement Target: Goal: Decrease by 3% the baseline 30-day readmissions rate for program participants. Data Source: Patient records; program analytics. **Outcome Improvement Target 1 Estimated Incentive Payment*:* $581,971**	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30 day readmission rate Improvement Target: Goal: Decrease by 5% the baseline 30-day readmissions rate for program participants Data Source: Patient records; program analytics. **Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,392,630**
Year 2 Estimated Outcome Amount: $317,427	**Year 3 Estimated Outcome Amount: $363,237**	**Year 4 Estimated Outcome Amount: $581,971**	**Year 5 Estimated Outcome Amount: $1,392,630**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,655,265			

Central Texas Medical Center
Category 4 DSRIP Projects

CATEGORY 4 POPULATION-FOCUSED IMPROVEMENTS
Central Texas Medical Center

Provider Information

Performing Provider Name: Central Texas Medical Center
Performing Provider TPI: 121789503
Related Category 1 or 2 Project: Expanding Primary Care Capacity for low-income Adult Residents of Hays County, TX 121789503.1.1
IGT Entity for DYs 1 – 5: Hays County

Domain 1 – Potentially Preventable Admissions (8 measures)
Relationship to Categories 1 – 3 and Expected Domain Improvements DYs 2 - 5

Central Texas Medical Center will be performing one project: Expanding Primary Care capacity for low-income residents of Hays County, TX. Through the establishment of a new primary care clinic, this project will offer expanded (to include evening hours) and integrated health care services to low-income adult residents of Hays County. In Hays County, low-income, uninsured adult residents have limited or few options for accessing primary care services This places a significant burden on hospital emergency departments within the County and RHP. Emergency departments become the only option for this targeted population to be treated by a physician and/or access care after hours. Patients that are medically screened and treated in an ED settling likely struggle with uncoordinated care and may not have the resources or funding to follow discharge instructions including access to prescriptions and appropriate follow-up/after care. This can lead to Potentially Preventable Admissions (PPAs). By establishing a medical home, patients are in a more favorable position to effectively management their health conditions, especially complex or chronic disease processes. Consistent and coordinated outpatient care reduces a patient's susceptibility to acute episodes of illness which may prompt them to seek high cost "rescue care", primary care that is obtained through an emergency department leading to a PPA. The Category 3 Outcome metric for this project is IT-9.2 (ED appropriate utilization); by reducing emergency department visits and providing options for accessible outpatient care, PPAs may also be reduced.

While we will report on all 8 measures, the PPA categories most pertinent to the populations to be served by this project are PPAs for: congestive heart failure, diabetes, chronic obstructive pulmonary disease and hypertension.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY 3-5
Total Value	$76,100	$83,500	$91,500	$251,100
IGT Required	$30,592	$33,567	$36,783	$100,942

Valuation considered the size and scope of the plan, overall value and priority of this project within the community, demographics of the target population, waiver goals, financial investment/infrastructure

development, and the identified needs of the target population. Cost avoidance, especially reduced reliance on high cost emergency department care and PPAs was also factored into the overall valuation of this domain.

System Changes Necessary to Successfully Report Category 4:

More robust tracking of admission rates for the targeted population through a regional health information exchange system will be necessary to most effectively track and report PPAs.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Relationship to Categories 1 – 3 and Expected Domain Improvements DYs 2 – 5:

It is anticipated that expanding primary care capacity for low-income adult residents of Hays County will increase/improve access, provide better management of chronic and/or complex diseases and be a step in the right direction to break the cycle of high cost emergency room reliance for primary care services. Additionally, this project will also provide a referral option for emergency department personnel, hospital-based case managers and social workers when they identify patients medically appropriate for project services. Therefore, just as this project may impact PPAs, it is also expected that coordinated outpatient care should reduce Potentially Preventable Readmissions (PPRs) within 30 days as well.

While we will report on all 7 measures, the specific PPRs will be the same or similar to the identified PPAs including: congestive heart failure, diabetes, and chronic obstructive pulmonary disease. The project's Category 3 outcome metric of IT-9.2 (ED appropriate utilization) is also tied to reducing PPRs.

Valuation and Rationale:

	DY3	**DY4**	**DY5**	**Total DY 3-5**
Total Value	$76,100	$83,500	$91,500	$251,100
IGT Required	$30,592	$33,567	$36,783	$100,942

Valuation considered the size and scope of the plan, overall value and priority of this project within the community, demographics of the target population, waiver goals, financial investment/infrastructure development, cost avoidance and the identified needs of the target population.

System Changes Necessary to Successfully Report Category 4:

More robust tracking of admission rates for the targeted population through a regional health information exchange system will be necessary to most effectively track and report PPAs.

Domain 3: Potentially Preventable Complications (64 measures)

Relationship to Categories 1 – 3 and Expected Domain Improvements DYs 2 – 5:

Hays County was the fastest growing county in the RHP between 2000 – 2010 growing 61% during the decade. The County is projected to grow an additional 36% by 2016 with large projected growth for residents aged 55 – 64. The growth in this age group is significant because potentially preventable complications are more likely in an aging population, especially those with multiple and complex medical needs. This is compounded when consistent access to primary, specialty and outpatient diagnostic care is unavailable or delayed. Expanding access to primary care will promote consistent and comprehensive care encouraging patient compliance and adherence to improved lifestyle and medication regimens. Patients with a better overall health status reduce their propensity to potentially preventable complications (PPCs). PPCs can lead to longer lengths of stay, resource-intense discharge planning activities, and/or the necessity for admission to a post acute care setting.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY 3-5
Total Value	N/A	$83,500	$91,500	$175,100
IGT Required	N/A	$33,567	$36,783	$70,350

Valuation considered the size and scope of the plan, overall value and priority of this project within the community, demographics of the target population, waiver goals, financial investment/infrastructure development, and the identified needs of the target population. Cost avoidance was also a factor as it is expected that high cost care will be reduced through less hospitalizations, shorter lengths of stay and/or reduced reliance on post-acute care services such as home health, skilled nursing or long term acute care.

System Changes Necessary to Successfully Report Category 4:

More robust tracking of admission rates for the targeted population through a regional health information exchange system will be necessary to most effectively track and report PPAs.

Domain 4: Patient-Centered Healthcare (2 measures)

Relationship to Categories 1 – 3 and Expected Domain Improvements DYs 2 – 5:

It is anticipated that timely access to outpatient healthcare services will positively impact a patient's experience during their inpatient stay. Patients often experience anxiety and fear during an inpatient stay which is significantly compounded when access to care upon discharge, including prescription medications, is non-existent or not readily available. Expanding access to primary care services for an at-risk population will provide a needed "linkage" between hospital discharge planners and the patient's medical home thus improving the chances for successful healthcare outcomes that improve the patient experience of care, satisfaction, quality of care and lessened potential for preventable future hospital admissions and/or re-admissions. Medication reconciliation at discharge will educate the patient as to the importance of taking medications as prescribed and/or discontinue medications that are no longer necessary.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY 3-5
Total Value	$76,100	$83,500	$91,500	$175,100
IGT Required	$30,592	$33,567	$36,783	$100,942

Valuation considered overall value and priority of this project within the community, demographics of the target population, waiver goals, cost avoidance and the identified needs of the target population.

System Changes Necessary to Successfully Report Category 4:

Central Texas Medical Center currently distributes the HCAHPS survey. If it is necessary, a system will need to be devised to isolate the survey responses of project participants. CTMC is currently able to report medication reconciliation activities via their electronic health record.

Domain 5: Emergency Department (1 measure)

Relationship to Categories 1 – 3 and Expected Domain Improvements DYs 2 – 5:

It is not expected that emergency department patient through-put time will be directly impacted by our Category 1 project. However, it is reasonable to correlate that providing care in the right setting at the right time and potentially reducing utilization of higher cost healthcare resources such as the ED will create overall efficiencies for area emergency departments.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY 3-5
Total Value	$76,100	$83,500	$91,500	$175,100
IGT Required	$30,592	$33,567	$36,783	$100,942

Valuation considered overall value and priority of this project within the community, demographics of the target population, waiver goals, cost avoidance and the identified needs of the target population.

System Changes Necessary to Successfully Report Category 4:

Central Texas Medical Center is currently able to capture this data via their electronic health record.

Optional Domain 6: Children and Adult Core Measures (8 measures)

At this time, Central Texas Medical Center has elected to not report on this optional domain.

Category 4: Population-Focused Measures: *Central Texas Medical Center/121789503*				
	Year 2 (10/1/2012 – 9/30/2013)	**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 (Semi-annual reporting periods 1: (October 1 – March 31) or 2: (April 1 – September 30)	**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	$170,250	$76,100		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$76,100	$83,500	$91,500
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive		$76,100	$83,500	$91,500
Domain 3: Potentially Preventable Complications (PPCs): Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive			$83,500	$91,500
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Medication Management				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive		$76,100	$83,500	$91,500
Domain 5: Emergency Department				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive		$76,100	$83,500	$91,500
Domain 6: Not selected by Provider				
Grand Total Payments Across Category 4	$170,250	$380,500	$417,500	$457,500
Total Category 4: 1,425,750				

Community Care Collaborative

Category 4 DSRIP Projects

Performing Provider Name: **Community Care Collaborative (CCC)**
Performing Provider TPI: **3074593021**

The Community Care Collaborative (CCC) will report on all required measures in the five Reporting Domains (RD), using data from University Medical Center Brackenridge (UMCB). UMCB is Travis County's public hospital, owned by Central Health and operated by the Seton Healthcare Family. As the Travis Healthcare District, Central Health is responsible for providing indigent care to county residents. Together with Seton, it created the CCC in 2012.

During DY2 and DY3, the CCC will evaluate and test data systems, including the proposed Category 1 Disease Management Registry project (307459301.1), to establish reliable and progressively stronger performance measurement and reporting throughout each Reporting Domain.

Domain 1: Potentially Preventable Admissions (8 measures)

Description –Potentially Preventable Admissions are often linked to poor chronic disease management and inadequate access to appropriate and accessible outpatient primary care, specialty care, and behavioral health care services. Through expanded access to care, improved patient navigation, and effective coordination between providers across the continuum of care, the CCC aims to address the root causes of potentially preventable admissions through its fourteen Category 1 and 2 DSRIP projects, including:

- Chronic Care Management Model for Individuals with Multiple Chronic Conditions (307459301.2.2)
- Expanded Primary Care Hours at Community Based Outpatient Settings (307459301.1.2)
- Community Paramedic Patient Navigation (307459301.2.6)
- Telepsychiatry at Community Based Clinics (307459301.1.8)

In addition, key related Category 3 outcomes that will help lead to a reduction in potentially preventable admissions include:

- IT-9.2: ED Appropriate utilization
- IT-1.6: Cholesterol management for patients with cardiovascular conditions
- IT-1.11: Diabetes Care: Blood Pressure Control (<140/90 mm/Hg)
- IT-10.6: Functional status assessment for complex chronic conditions-Percentage of patients with two or more high impact conditions who completed initial and follow-up (patient reported) functional status assessments
- IT-2.5: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate

Valuation

RD 1	DY3	DY4	DY5	Total DY 3-5
Total Value	1,153,681	1,216,250	1,281,326	3,651,257
IGT Required	476,586	502,433	529,316	1,508,335

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Description –Once patients have been discharged from the hospital, the CCC recognizes the role that a strong medical home model, evidence-based post-discharge regimens, and patient navigation services play

in minimizing potentially preventable readmissions. The CCC is implementing a number of Category 1 and 2 DSRIP projects to identify and support patients in need of follow-up services, including:

- Patient Centered Medical Home Model (307459301.2.1)
- Chronic Care Management Model for Individuals with Multiple Chronic Conditions (307459301.2.2).

The CCC anticipates that related Category 3 outcomes for improved chronic disease management realized through its Category 1 and 2 projects will also help reduce the likelihood of potentially preventable 30-day readmissions:

- IT-1.6: Cholesterol management for patients with cardiovascular conditions
- IT-1.11: Diabetes Care: Blood Pressure Control (<140/90 mm/Hg)
- IT-10.6: Functional status assessment for complex chronic conditions-Percentage of patients with two or more high impact conditions who completed initial and follow-up (patient reported) functional status assessments

Valuation

RD 2	DY3	DY4	DY5	Total DY 3-5
Total Value	1,153,681	1,216,250	1,281,326	3,651,257
IGT Required	476,586	502,433	529,316	1,508,335

Domain 3: Potentially Preventable Complications (64 measures)

Description – The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. Through its Disease Management Registry (307459301.1) and other projects, the CCC will ensure that providers have access to real-time clinical data, reports, reminders, and analytics to support improved decision making at the point of care, minimizing medical errors and potentially preventable complications. This enhanced information will help reduce PPCs when patients present for inpatient care. Knowing a patient's full history at that "point of entry" will aid both in measuring PPCs (by distinguishing which conditions may have been present at admission) and also keeping PPCs from occurring (by recognizing which risk factors a patient may exhibit prior to admission).

Valuation

RD 3	DY3	DY4	DY5	Total DY 3-5
Total Value	N/A	1,216,250	1,281,326	2,497,576
IGT Required	N/A	502,433	529,316	1,031,749

Domain 4: Patient-Centered Healthcare (2 measures)

Description – The Patient-Centered Healthcare measure in this domain will identify the success of the CCC in improving the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems. CCC DSRIP projects will also support the Medication Management measure in this domain by empowering patients to take an active role in their treatment and providing clinicians with real-time clinical data for improved decision making and patient monitoring. Related projects include:

- Disease Management Registry (307459301.1)

- Patient Centered Medical Home Model (307459301.2.1)
- Chronic Care Management Model for Individuals with Multiple Chronic Conditions (307459301.2.2)

The CCC anticipates that improved patient satisfaction scores (IT-6.1) associated with a variety of Category 1 and 2 projects in community-based outpatient settings will also lead to improved satisfaction throughout the continuum of care, including the hospital setting.

Valuation

RD 4	DY3	DY4	DY5	Total DY 3-5
Total Value	1,153,681	1,216,250	1,281,326	3,651,257
IGT Required	476,586	502,433	529,316	1,508,335

Domain 5: Emergency Department (1 measure)

Description – Through improved communication and coordination among providers as well as the availability of real-time data for clinical decision making, the CCC expects to reduce Admit Decision Time to Emergency Department (ED) Departure Time. CCC projects that help achieve these goals include:

- Disease Management Registry (307459301.1)
- Patient Centered Medical Home Model (307459301.2.1)
- Chronic Care Management Model for Individuals with Multiple Chronic Conditions (307459301.2.2).

In addition, expanded access to primary care and improved patient navigation through the CCC's Category 1 and 2 DSRIP projects will ensure that patients receive the right services in the right place at the right time. Reducing overutilization of the ED (IT-9.2) will relieve additional hospital resources to improve patient throughput in Reporting Domain 5.

Valuation

RD 5	DY3	DY4	DY5	Total DY 3-5
Total Value	1,153,681	1,216,250	1,281,326	3,651,257
IGT Required	476,586	502,433	529,316	1,508,335

Across all domains:
DY2: $2,709,579
DY3: $5,768,405
DY4: $6,081,250
DY5: $6,406,630
TOTAL: $20,965,864

Category 4: Population-Focused Measures *Community Care Collaborative/307459301*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$2,709,579	$1,153,681		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive		$1,153,681	$1,216,250	$1,281,326
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive		$1,153,681	$1,216,250	$1,281,326
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$1,216,250	$1,281,326
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 - 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 - 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive		$1,153,681	$1,216,250	$1,281,326
Domain 5: Emergency Department				
Measurement period for report		4/1/2014 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 - 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive		$1,153,681	$1,216,250	$1,281,326
Domain 6 Not Selected by Performing Provider				
Grand Total Payments Across Category 4 (Total all years: $20,965,864)	$2,709,579	$5,768,405	$6,081,250	$6,406,630

Dell Children's Medical Center
Category 4 DSRIP Projects

Category 4 Population-Focused Improvements
Dell Children's Medical Center of Central Texas

Performing Provider Name: Dell Children's Medical Center of Central Texas
Performing Provider TPI: 186599002
Related Category 1 or 2 Project: multiple
IGT Entity for DYs 1-5: Central Health

Domain 1 - Potentially Preventable Admissions (8 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5
Dell Children's Medical Center will be performing three projects: Care Management for Chronically Ill Children and Adolescents School-based Behavioral Health Services, and Family and Child Obesity. All three programs are expected to impact Potentially Preventable Admissions (PPAs). The Chronic Care Management project will identify and manage a population of children with very high disease complexity and deliver comprehensive integrated care. This population represents a disproportionate share of pediatric healthcare expenses, including those related to PPAs. The Category 3 Outcome metric for this project is IT-9.2 (ED appropriate utilization); by reducing pediatric Emergency Department visits, PPAs may also be reduced. In general, providing comprehensive integrated primary care to these children, to include 24/7 call coverage, accessible sick visits, subspecialist care, palliative care, behavioral medicine, and psychiatric care, may also have an impact on reducing PPAs.

Providing School-based Behavioral Health Services is also intended to help reduce PPAs and generally improve quality of life for students needing these services. Like the chronic care management program, this program is also intended to increase the number of "well" and productive days experienced by these patients, which means avoiding unnecessary hospitalizations. The program will identify students with unmet behavioral health needs and provide psychotherapy and medication management at school. More specifically, the Category 3 outcome measure (IT-1.20) is intended to increase suicide risk assessments for program participants with a diagnosis of major depressive disorder.

The Family and Child Obesity program prevents and treats childhood obesity. Because children with obesity are two to three time more likely to be hospitalized, this outpatient-based program is expected to avoid or reduce the number of hospitalizations for children. The Category 3 outcome measure (IT-9.6) examines the patient and family education features of the program that provide life-long tools to children and their families to prevent obesity, and related comorbidities, for the entire family unit.

The PPA categories most pertinent to the populations to be served by these projects are Hypertension, Diabetes, Behavioral Health and Substance Abuse, and Pediatric Asthma. The provision of direct primary care services and the linkage with the healthcare system provided by school-based services will also impact the remaining measures in this domain related to immunization. At the same time, the hospital already has systems in place to identify every inpatient's need for these immunizations and to administer them if appropriate.

The ability for these projects to have a statistically significant impact on the whole community's rates of PPAs has not been determined; it is likely dependent on the percentage of the community represented by the projects and the current level of healthcare utilization for the projects' participants.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$177,469	$390,635	$416,461	$984,565
IGT Required	$71,520	$157,426	$167,834	$396,780

Valuation considered costs, cost avoidance, population impact, patient experience, the overall impact to the community, as well as the project's ability to transform the delivery of healthcare by providing the right care, at the right place, the right time, and in the most cost efficient way for the patient and family unit. This Outcome Measure is expected to be substantially impacted by this project for the population being served for reasons stated above. Its value was set equal to the value for Domain 2.

System Changes Necessary to Successfully Report Category 4:

Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Just as these projects may impact PPAs, for patients who are hospitalized, the continued services provided should serve to reduce Potentially Preventable Readmissions (PPRs) within 30 days as well. All of the projects will utilize models that will provide more intensive services as necessary to patients who are initially hospitalized in order to avoid unnecessary readmissions.

Again, the specific PPRs expected to be impacted are those related to Diabetes, Hypertension, Behavioral Health and Substance Abuse, and Pediatric Asthma. The prevalence of these chronic conditions in the target populations will determine the extent to which these specific indicators are impacted. The All-Cause Readmission Rate will be applicable to all project participants who are hospitalized. However, the ability for these projects to have a statistically significant impact on the whole hospital's rate of PPRs has not been determined; it is likely dependent on the percentage of the hospital's discharges represented by the projects' participants. Certainly, applicable learnings from the projects will be adopted by the hospital as part of ongoing performance improvement initiatives. This could lead to a more substantial impact.

The projects' Category 3 outcome metrics of IT-9.2 (ED appropriate utilization) IT-1.20 (Suicide risk assessment) are also tied to reducing PPRs.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$88,734	$390,635	$416,461	$895,830
IGT Required	$35,760	$157,426	$167,834	$361,020

Valuation considered costs, cost avoidance, population impact, patient experience, the overall impact to the community, as well as the project's ability to transform the delivery of healthcare by providing the right care, at the right place, the right time, and in the most cost efficient way for the patient and family unit. This Outcome Measure is expected to be substantially impacted by this project for the population being served for reasons stated above. Its value was set equal to the value for Domain 1.

System Changes Necessary to Successfully Report Category 4:

Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis for patients seen in Seton hospitals. For readmissions, in particular, this will make it possible to track patients admitted initially to University Medical Center Brackenridge and then readmitted to any Seton hospital. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 3: Potentially Preventable Complications (64 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Potentially Preventable Complications (PPCs) are not expected to be explicitly impacted via these projects, although it is possible there may be some tangential effect on any of the PPCs that are impacted by patient behavior or compliance (e.g., falls prevention). Also, simply keeping fragile patients out of the hospital will make it impossible for them to be subject to PPCs. However, there are other quality improvement efforts being conducted by the hospital toward this end.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	NA	$48,830	$52,057	$100,887
IGT Required	NA	$19,678	$20,979	$40,657

Because PPCs are not expected to be explicitly impacted, its value is significantly lower than Domain 1 or 2.

System Changes Necessary to Successfully Report Category 4:

Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis for patients seen in Seton hospitals. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 4: Patient-Centered Healthcare (2 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

The improved primary care and care management services that will be utilized by the Chronic Care Management project will provide support for patients while they are in the hospital and when they leave the hospital. Thus, patients who are admitted to the hospital might be expected to respond favorably to their hospital experience, particularly their care upon leaving the hospital. They will also be well educated regarding their discharge medication lists and instructions. Similarly, the School-based Behavioral Health Services provided will also provide a linkage to community resources upon discharge in an effort to improve quality of life, which includes an element of patient satisfaction with care received. By treating and educating the entire family unit, the Family and Child Obesity project is expected to improve the patient experience, however this an outpatient intervention and not expected to impact HCAHPS scores.

These measures will be applicable to all project participants who are hospitalized. However, the ability for this project to have a statistically significant impact on the whole hospital's patient satisfaction and medication reconciliation rate has not been determined; it is likely dependent on the percentage of the hospital's discharges represented by the project's participants. Certainly, applicable learnings from the project will be adopted by the hospital as part of ongoing performance improvement initiatives. This could lead to a more substantial impact.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$44,367	$97,649	$104,116	$246,132
IGT Required	$17,880	$39,353	$41,959	$99,192

Valuation considered population impact, patient experience and the overall impact to the community. For the reasons stated above, its impact on survey results is expected to be minimal. However, the potential for this project to support the patient medication management rates through applicable learnings increase its value above Domain 3.

System Changes Necessary to Successfully Report Category 4

Dell Children's Medical Center currently contracts with Professional Research Consultants, Inc. to conduct patient satisfaction surveys, including the HCAHPS measures. If it is necessary to isolate the surveys of project participants, we will work with our vendor to create this capability. Regarding medication reconciliation, our audit process will be revised to accommodate reporting this measure.

Domain 5: Emergency Department (1 measure)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Emergency Department (ED) through-put time is not expected to be explicitly impacted by these projects. However, there are other quality improvement efforts being conducted by the hospital toward this end.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$44,367	$48,830	$52,057	$145,254
IGT Required	$17,880	$19,678	$20,979	$58,537

Because ED through-put times are not expected to be explicitly impacted by most of the projects, its value is significantly lower than Domains 1 or 2.

System Changes Necessary to Successfully Report Category 4
Dell Children's Medical Center's electronic medical record has the capacity to capture these data. The appropriate reports will be written to aggregate and report out this metric.

Optional Domain 6: Children and Adult Core Measures (8 measures)
At this time, Dell Children's Medical Center will not report on this optional domain.

Category 4: Population-Focused Measures Dell Children's Medical Center– TPI: 186599002				
	Year 2 (10/1/2012 – 9/30/2013)	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 (Semi-annual reporting periods 1: (October 1 – March 31) or 2: (April 1 – September 30)	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domain 3.		
Estimated Maximum Incentive Amount	$332,217	$532,407		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive		$177,469	$390,635	$416,461
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive		$88,734	$390,635	$416,461
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive			$48,830	$52,057
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		4/1/2014 – 3/31/2015	4/1/2014 – 3/31/2015	4/1/2014 – 3/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive		$44,367	$97,649	$104,116
Domain 5: Emergency Department				
Measurement period for report		4/1/2014 – 3/31/2015	4/1/2014 – 3/31/2015	4/1/2014 – 3/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum		$44,367	$48,830	$52,057
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6: Not selected by Performing Provider				
Grand Total Payments Across Category 4	**$332,217**	**$887,344**	**$976,579**	**$1,014,152**

Category 4 Grand Total = $3,237,292

St Mark's Medical Center
Category 4 DSRIP Projects

Performing Provider Name: St. Mark's Medical Center ("SMMC")
Performing Provider TPI #: 176692501

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – SMMC will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. This domain is related to SMMC's Cat. 1 Project (Expanding Access to Specialty Care) in that expanded access to specialty care should improve the number of potentially preventable admissions into the hospital, because Fayette County and Lee County patients will be receiving earlier interventions and preventative care from specialty care physicians before complications escalate into more urgent issues.
- **Valuation**
    - **Rationale/Justification** – The value SMMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – SMMC will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community without follow-up or support, and end up back in the hospital inpatient setting soon thereafter. This domain is related to SMMC's Cat. 1 Project (Expanding Access to Specialty Care) in that expanded access to post-discharge specialty care should improve the number of potentially preventable readmissions into SMMC.
- **Valuation**
    - **Rationale/Justification** - The value SMMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – SMMC will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and SMMC is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. This domain is related to SMMC's Cat. 1 Project (Expanding Access to Specialty Care) in that by having increased access to specialty care, patients will be better able to receive preventive care and improve care outcomes before additional complications arise.

- **Valuation**
    - **Rationale/Justification** - The value SMMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially

preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – SMMC will report on Patient Satisfaction and Medication Management for this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. In contrast, patients may experience negative health outcomes and be even more unsatisfied. SMMC is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. This domain is related to SMMC's Cat. 1 Project (Expanding Access to Specialty Care) in that patient satisfaction regarding timeliness of receiving specialty care appointments should improve once patients have expanded access to specialty care services.
- **Valuation**
    - **Rationale/Justification** - The value SMMC placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from SMMC and how well SMMC performs its function of promoting medication management. SMMC is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain 5: Emergency Department (1 measure)

- **Description** – SMMC will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. SMMC is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold. This domain is related to SMMC's Cat. 1 Project (Expanding Access to Specialty Care) in that by having increased access to specialty care, patients will be better able to receive preventive care and improve care outcomes before emergency health situations arise, and will be less reliant on the ER to receive specialty care services.

- **Valuation**
    - **Rationale/Justification** - The value SMMC placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

<u>Optional</u> Domain 6: Children and Adult Core Measures (8 measures).

St. Mark's will not be participating in Domain 6.

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Category 4: Population-Focused Measures: St. Mark's Medical Center – TPI: 176692501				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$3,685	$1,865		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive		$1,865	$2,016	$1,367
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive		$1,865	$2,016	$1,367
Domain 3: Potentially Preventable Complications (PPCs): Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive			$2,016	$1,367
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1-Sept. 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Oct. 1-Sept. 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive		$1,865	$2,016	$1,367

Domain 5: Emergency Department				
Measurement period for report		Oct. 1-Sept. 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive		$1,865	$2,016	$1,367
Domain 6 Not Selected by Performing Provider				
Grand Total Payments Across Category 4	$3,685	$9,325	$10,080	$6,835

Total, Category 4: $29,925

University Medical Center at Brackenridge
Category 4 DSRIP Projects

Category 4 Population-Focused Improvements

Performing Provider Name: University Medical Center at Brackenridge (UMCB)
Performing Provider TPI: 137265806

Domain 1 - Potentially Preventable Admissions (8 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5

Nearly all of the projects to be undertaken by University Medical Center Brackenridge are expected to help to reduce potentially preventable admissions. Specific to behavioral health and substance abuse (BHSA) PPAs, projects 1.3 (Category 1.11), 1.1 (1.13), 1.2 (1.14), 2.3 (2.17), and 2.4 (2.17) are all aimed at providing better support to patients presenting to the Emergency Department with psychiatric care needs and providing outpatient follow-up and care navigation post-discharge. Category 3 outcomes IT-1.18 (outpatient followup after hospitalization) and IT-3.8 (BHSA 30 day readmissions) are related to this Domain. IT-6.1 (HCAHPS patient satisfaction) is another related Category 3 outcome to the extent by which improving patients' satisfaction with their discharge education improves their understanding and compliance.

Other projects are also aimed at providing care navigation services to patients. These include Care Transitions (2.5 (2.12)), Chronic Care Management (2.6 (2.2)), OB Navigation (2.1 (2.9)), Women's Oncology Navigation (2.8 (2.9)), Palliative Care Program (2.7 (2.1)), and Adult Diabetes Care (2.9). These projects can be expected to have more of an impact on the additional chronic conditions specifically called out in this domain (Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease or Asthma in Adults, Hypertension, or Pediatric Asthma), in addition to BHSA. The prevalence of these chronic conditions in the target populations will determine the extent to which these specific indicators are impacted.

Patient navigation services will also directly impact the remaining measures in this domain related to Bacterial pneumonia immunization and Influenza Immunization. At the same time, the hospital already has systems in place to identify every inpatient's need for these immunizations and to administer them if appropriate.

The remaining projects, Culturally Competent Care (1.5 (1.4)), Language Access and Resource Center (1.4 (1.4)), and Women's Oncology Screening (2.2 (2.7)), all aim to provide better access to care and improved patient education. These services can also be expected to at least tangentially result in a reduction of PPAs.

In addition, IT-9.2 (ED appropriate utilization) is a Category 3 outcome metric that is very much tied to reducing PPAs. IT-12.6 (Cancer screening followup) could also prevent PPAs by ensuring earlier cancer treatment. Additional related Category 2.12 Process and Improvement measures include P-3.1 (comprehensive care management program), P-5.1 (risk reduction program for patients with diabetes), I-10.1 (identify top chronic conditions and patient demographics), and for Category 2.2 I-18.1 (improve percentage of patients with self-management goals).

The ability for these projects to have a statistically significant impact on the whole community's rates of PPAs has not been determined; it is likely dependent on the percentage of the community

represented by the projects and the current level of healthcare utilization for the projects' participants.

Valuation

	DY3	DY4	DY5	Total DY3-5
Total Value	793,985	847,171	920,465	2,561,621
IGT Required	327,995	349,966	380,244	1,058,205

Valuation considered costs, cost avoidance, population impact, patient experience, the overall impact to the community, as well as the project's ability to transform the delivery of healthcare by providing the right care, at the right place, the right time, and in the most cost efficient way for the patient and family unit.

System Changes Necessary to Successfully Report Category 4:

Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

As for PPAs, nearly all of the projects to be undertaken by University Medical Center Brackenridge are expected also to help to reduce Potentially Preventable Readmissions (PPRs) within 30 days for patients who are admitted to the hospital. Specific to behavioral health and substance abuse (BHSA) PPAs, projects 1.3 (Category 1.11), 1.1 (1.13), 1.2 (1.14), 2.3 (2.17), and 2.4 (2.17) are all aimed at providing better support to patients presenting to the Emergency Department with psychiatric care needs and providing outpatient follow-up and care navigation post-discharge. Category 3 outcomes IT-1.18 (outpatient followup after hospitalization) and IT-3.8 (BHSA 30 day readmissions) are directly related to this Domain. IT-6.1 (HCAHPS patient satisfaction) is another related Category 3 outcome to the extent by which improving patients' satisfaction with their discharge education improves their understanding and compliance.

Other projects are also aimed at providing care navigation services to patients. These services are intended to help guide persons to the most appropriate care setting for their needs. For patients who are admitted to the hospital, this will include assistance with linkage to appropriate outpatient care follow-up, teaching on self-care and disease management, and other supportive services that should help to avoid PPRs for the populations being served. The applicable projects include Care Transitions (2.5 (2.12)), Chronic Care Management (2.6 (2.2)), OB Navigation (2.1 (2.9)), Women's Oncology Navigation (2.8 (2.9)), Palliative Care Program (2.7 (2.1)), and Adult Diabetes Care (2.9). These projects can be expected to have more of an impact on the additional chronic conditions specifically called out in this domain (Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease in Adults, Stroke, or Pediatric Asthma), in addition to BHSA, as well as overall (all cause) PPRs. The prevalence of these chronic conditions in the target populations will determine the extent to which these specific indicators are impacted.

The remaining projects, Culturally Competent Care (1.5 (1.4)), Language Access and Resource Center (1.4 (1.4)), and Women's Oncology Screening (2.2 (2.7)), all aim to provide better access to care and improved patient education. These services can also be expected to at least tangentially result in a reduction of PPRs.

In addition, IT-9.2 (ED appropriate utilization) is a Category 3 outcome metric that is very much tied to reducing PPRs. Additional related Category 2.12 Process and Improvement measures include P-3.1 (comprehensive care management program), P-5.1 (risk reduction program for patients with diabetes), I-10.1 (identify top chronic conditions and patient demographics), and for Category 2.2 I-18.1 (improve percentage of patients with self-management goals).

The All-Cause Readmission Rate will be applicable to all project participants who are hospitalized. However, the ability for these projects to have a statistically significant impact on the whole hospital's rate of PPRs has not been determined; it is likely dependent on the percentage of the hospital's discharges represented by the projects' participants. Certainly, applicable learnings from the projects will be adopted by the hospital as part of ongoing performance improvement initiatives. This could lead to a more substantial impact.

Valuation

	DY3	DY4	DY5	Total DY3-5
Total Value	793,985	847,171	920,465	2,561,621
IGT Required	327,995	349,966	380,244	1,058,205

Valuation considered costs, cost avoidance, population impact, patient experience, the overall impact to the community, as well as the project's ability to transform the delivery of healthcare by providing the right care, at the right place, the right time, and in the most cost efficient way for the patient and family unit.

System Changes Necessary to Successfully Report Category 4:

Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis for patients seen in Seton hospitals. For readmissions, in particular, this will make it possible to track patients admitted initially to University Medical Center Brackenridge and then readmitted to any Seton hospital. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 3: Potentially Preventable Complications (64 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

Potentially Preventable Complications (PPCs) are not expected to be explicitly impacted via these projects, although it is possible there may be some tangential effect on any of the PPCs that are impacted by patient behavior or compliance (e.g., falls prevention). However, there are other quality improvement efforts being conducted by the hospital toward this end.

Valuation

	DY3	DY4	DY5	Total DY3-5
Total Value	NA	847,171	920,465	1,767,636
IGT Required	NA	349,966	380,244	730,210

System Changes Necessary to Successfully Report Category 4:

Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis for patients seen in Seton hospitals. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 4: Patient-Centered Healthcare (2 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

The Patient Navigator models and improved primary care services that will be utilized by this project will provide support for patients while they are in the hospital and when they leave the hospital. Thus, patients who are admitted to the hospital might be expected to respond favorably to their hospital experience, particularly their care upon leaving the hospital. They will also be well educated regarding their discharge medication lists and instructions.

Several of the projects are using Category 3 IT-1.6 as their outcome measure which will measure patient satisfaction with outpatient/provider services and ties directly to the inpatient patient satisfaction measures.

These measures will be applicable to all project participants who are hospitalized. However, the ability for this project to have a statistically significant impact on the whole hospital's patient satisfaction and medication reconciliation rate has not been determined; it is likely dependent on the percentage of the hospital's discharges represented by the project's participants. Certainly, applicable learnings from the project will be adopted by the hospital as part of ongoing performance improvement initiatives. This could lead to a more substantial impact.

Valuation

	DY3	DY4	DY5	Total DY3-5
Total Value	793,985	847,171	920,465	2,561,621
IGT Required	327,995	349,966	380,244	1,058,205

Valuation considered population impact, patient experience and the overall impact to the community.

System Changes Necessary to Successfully Report Category 4

University Medical Center Brackenridge currently contracts with Professional Research Consultants, Inc. to conduct patient satisfaction surveys, including the HCAHPS measures. If it is necessary to isolate the surveys of project participants, we will work with our vendor to create this capability. Regarding medication reconciliation, our audit process will be revised to accommodate reporting this measure.

Domain 5: Emergency Department (1 measure)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Emergency Department (ED) through-put time is not expected to be explicitly impacted via most of these projects. However, two projects, Psychiatric Emergency Department (1.1 (1.13)) and Psychiatric Telemedicine (1.3 (1.11)), may help to reduce ED waiting time for patients presenting with psychiatric needs. In addition, there are other quality improvement efforts being conducted by the hospital toward this end.

Valuation

	DY3	DY4	DY5	Total DY3-5
Total Value	793,985	847,171	920,465	2,561,621
IGT Required	327,995	349,966	380,244	1,058,205

System Changes Necessary to Successfully Report Category 4
University Medical Center Brackenridge's electronic medical record has the capacity to capture these data. The appropriate reports will be written to aggregate and report out this metric.

Optional Domain 6: Children and Adult Core Measures (8 measures)
At this time, University Medical Center Brackenridge will not report on this optional domain.

Category 4: Population-Focused Measures University Medical Center Brackenridge– TPI: 137265806				
	Year 2 **(10/1/2012 – 9/30/2013)**	**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				
(Semi-annual reporting periods 1: (October 1 – March 31) or 2: (April 1 – September 30)	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, & 5.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Capability: Estimated Maximum Incentive	1,706,517	794,020		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive		794,020	852,888	925,868
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive		794,020	852,888	925,868
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive			852,888	925,868
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive		794,020	852,888	925,868
Domain 5: Emergency Department				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		794,020	852,888	925,868
Domain 6 Not Selected by Performing Provider				
Grand Total Payments Across Category 4	**$ 1,706,517**	**$ 3,970,100**	**$ 4,264,440**	**$ 4,629,340**

Category 4 Grand Total = $14,570,397